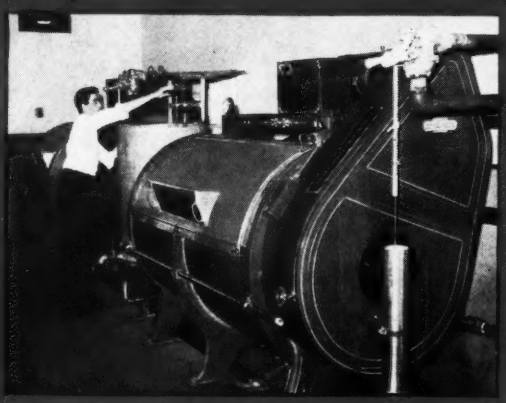
August, 1956

Canadian Hospital

- *What of the Future?*
- *Hospital Pharmacy Survey*
- *Western Canada Institute*
- *People and the Supplies they Use*
- *Bed Needs under General Insurance*
- *Nursing Service Administration Conference*

Canadian Hospital Association



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Whether you are planning a new laundry or want to reduce your present operating costs, it will pay you to have a Canadian Consultant call.

You can depend on your Canadian Laundry Consultant's advice in your selection of equipment from the *complete Canadian Line.* Backed by our many years experience in planning and equipping laundries, he can help solve your clean linen problems. Ask for his specialized assistance anytime . . . no obligation.

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Contents

Vol. 33 AUGUST, 1956 No. 8

(For Subscription rates see page 69)

PATIENT COMFORT AND LONG-TERM ECONOMY BUILT INTO

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Airfoam, made only by Goodyear, the world's finest cushioning, is ideal for hospitals, nurses residences and institutions—Airfoam mattresses and upholstered furniture bring comfort and relaxation to both patients and nursing staff.

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Airfoam products are dust and lint free, a distinct advantage for people who suffer from asthma or allergies caused by conventional materials. Airfoam mattresses are sanitary and readily sterilized by sponging or spraying with mild disinfectants. Removable, zipper-type covers facilitate washing.

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Notes About People

Gladys M. Porter,
Secretary-Treasurer
Maritime Hospital Association

(This is the second in a series introducing secretaries of provincial hospital associations.)

Gladys M. Porter, secretary-treasurer of the Maritime Hospital Association, leads a very active and full life. Indeed, she is active in so many community affairs that it is a source of continual amazement to her friends how she manages to accomplish so much. At the recent meeting of the Maritime Hospital Association (see July issue, page 48), her usual efficiency was very much in evidence. She is indeed so much a part of the Maritime Hospital Association that it would be very difficult to visualize a convention of that association without her.

Mrs. Porter was born in Sydney, N.S. Her father was the late Wallace A. Richardson, newspaper editor and first mayor of the city of Sydney. Her mother, Christina MacPherson Richardson, was for many years president of the senior hospital auxiliary, Sydney, and it was during these years that Mrs. Porter first became acquainted with and interested in hospitals.

Mrs. Porter takes a very broad interest in community affairs. In 1946 she was made a Member of the British Empire for her services in organizing the Women's Voluntary Corps in Nova Scotia and for other voluntary work. She is a member of the board of Blanchard-Fraser Memorial Hospital, Kentville, N.S., and has been president of the senior auxiliary for the past fourteen years. President of the Kings County Children's Aid Society since 1947, she was elected recently as president of the Nova Scotia Children's Aid Society. She has received awards from the St. John's Ambulance Corps and the Red Cross for service to these organizations.

Mrs. Porter is very much interested also in municipal affairs. Elected to the town council of Kentville, N.S., in 1943, she was the first woman mayor in eastern Canada and is still the only woman to hold that office in the Atlantic provinces. She is a member of the executive of the Canadian Federation of Mayors; chairman of the hospital civil defence committee of Nova Scotia; a member of the governing board

Gladys M. Porter

of Nova Scotia Training School; and is county chairman of the Salvation Army, cancer, poliomyelitis, and other fund-raising campaigns. Notwithstanding these many activities, she gives very generously of her time to her own hospital and to the affairs of the Maritime Hospital Association.

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Atomic Radiation Committee

Secretary-General Dag Hammarskjold has appointed Dr. Raymond K. Appleyard, at present acting secretary, as one of three scientific secretaries to serve on the staff of the Scientific Committee on the Effects of Atomic Radiation. From 1953 until joining the Secretariat, Dr. Appleyard has been carrying on fundamental research within the Biology Division of the Atomic Energy of Canada Limited, Chalk River, Ont. He has been released by the Canadian Government for his new assignment. He had been an instructor in bio-physics at Yale University and from 1951-1953 held a Rockefeller Foundation Fellowship in natural sciences at the Biology Division of California Institute of Technology.

• • • •

Dr. J. H. Grove Honoured for Restoration of Vision Work

Dr. J. H. Grove, chief of the Blindness Control Division of the Department of National Health and Welfare, was elected an Associate Member of the Canadian Ophthalmological Society at its recent annual meeting at Quebec. This unusual honour was given in recognition of his work for the control of blindness, the administration of the restoration of vision treatment scheme for blind pensioners in co-operation with the provinces, and for his interest in Glaucoma Clinics and Eye Research under the National Health Program. Dr. Grove studied medicine at Oxford and Toronto, and served in both World Wars. At the end of the second World War he entered the civil service as a medical advisor to the Canadian Pension Commission, and in 1948 he became chief of the Blindness Control Division.

• • • •

William H. Markey

The death of William H. Markey, Jr., director of financial management services for the Catholic Hospital Association of the United States and Canada occurred on June 30th in the Grand Canyon airplane disaster. After seven years as a public accountant, he entered the hospital field in the Pittsburgh area in 1941. While associated with the American Hospital Association, 1946-1952, Mr. Markey was the author, with advisory committee assistance, of the manual *Uniform Hospital Statistics and Classification of Accounts.* In addition to his duties at the Catholic Hospital Association, he was an instructor in the course in hospital administration in the graduate school, St. Louis University. Mr. Markey was well known through contacts made at various institutes and workshops, and had served as special advisor to various hospitals concerning business and financial management. He is survived by his wife and five children.

• • • •

New Administrative Assistant at R.V.H.

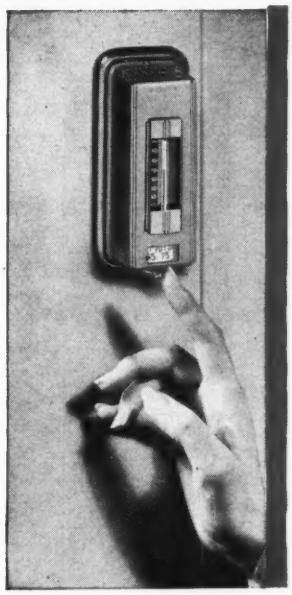
Dr. Robert F. Ingram has been appointed administrative assistant at the Royal Victoria Hospital, Montreal, P.Q., where he has recently completed his administrative residency. Dr. Ingram was a member of the class of the 1954-55 University of Toronto's course in Hospital Administration.

• • • •

Administrator for Hospital Under Construction

R. Ray Copeland, administrator of Port Colborne General Hospital, Port Colborne, Ont., has been appointed administrator of South Peel Hospital, Port Credit, Ont., scheduled for completion in October, 1957. Mr. Copeland is on the board of directors of the Ontario Hospital Association, a

(Continued on page 16)



How to Get the Most from Your Fuel Dollars

It takes the right control system for waste-free operation of heating and cooling equipment.

Most hospital administrators are well aware of the money-saving possibilities of installing the most efficient possible heating, ventilating and air conditioning equipment. But that's only the *first step* towards fuel economy!

What ultimately determines your operating costs is the way you *control* this equipment—with the proper thermostats, valves, dampers and other control apparatus. Obviously, even the most efficient heating or air conditioning plant actually saves you very little if you are needlessly wasting part of its output.

The better the control system, the more money you save in operating costs. And for the *finest* in control, there's only one possible answer—Johnson Control. The reasons are simple. First, Johnson gives you the benefit of over 70 years' experience in solving the temperature control problems of all kinds of hospitals—*more specialized experience than anyone else!*

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Equally important, *every* Johnson System, small or large, is especially engineered to meet the exact needs of the particular heating, ventilating or air conditioning installation. And only Johnson's *own* full-time engineers and mechanics plan and install Johnson Control Systems. Each installation, *whether it involves a single operating room or an entire hospital,* is made exactly as planned. As a result, Johnson Control is unsurpassed not only for economy, but for accuracy and dependability as well.

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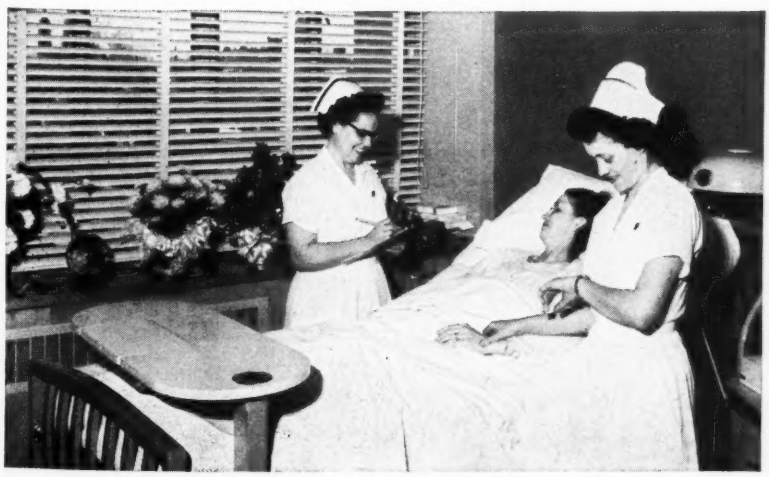
It's tops in safety features, too. Pneumatically operated Johnson Control is completely safe, even in the presence of explosive gases.

Whether you are planning a new building or modernizing an existing hospital, why not look further into this matter of automatic temperature and humidity control now? Get all the facts on these and other money-saving features of Johnson Control. An engineer from a nearby Johnson branch office will gladly make recommendations without obligation, or write for more information to Johnson Temperature Regulating Co. of Canada Ltd., Toronto 16, Ontario. Direct Branch Offices in Principle Cities across Canada.



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Notes About People

(Continued from page 12)

member of the American College of Hospital Administrators, and is a graduate of the extension course in hospital organization and management sponsored by the Canadian Hospital Association.

Margaret Glynn

Appointment of Chief Medical Record Librarian

Margaret Glynn has been appointed chief medical record librarian at Queensway General Hospital, Toronto, Ont. Miss Glynn is a graduate of the School for Medical Record Librarians, Hotel Dieu Hospital, Kingston, Ont., and she will be among the Canadians participating in the Second International Congress on Medical Records to be held from October 1 to 5th at the Shoreham Hotel, Washington, D.C.

• • • •

Lambert Lodge Appointment

Kenneth S. Meredith, formerly administrator of Queensway General Hospital, Toronto, Ont., has been appointed assistant superintendent of Lambert Lodge, Toronto, Ont.

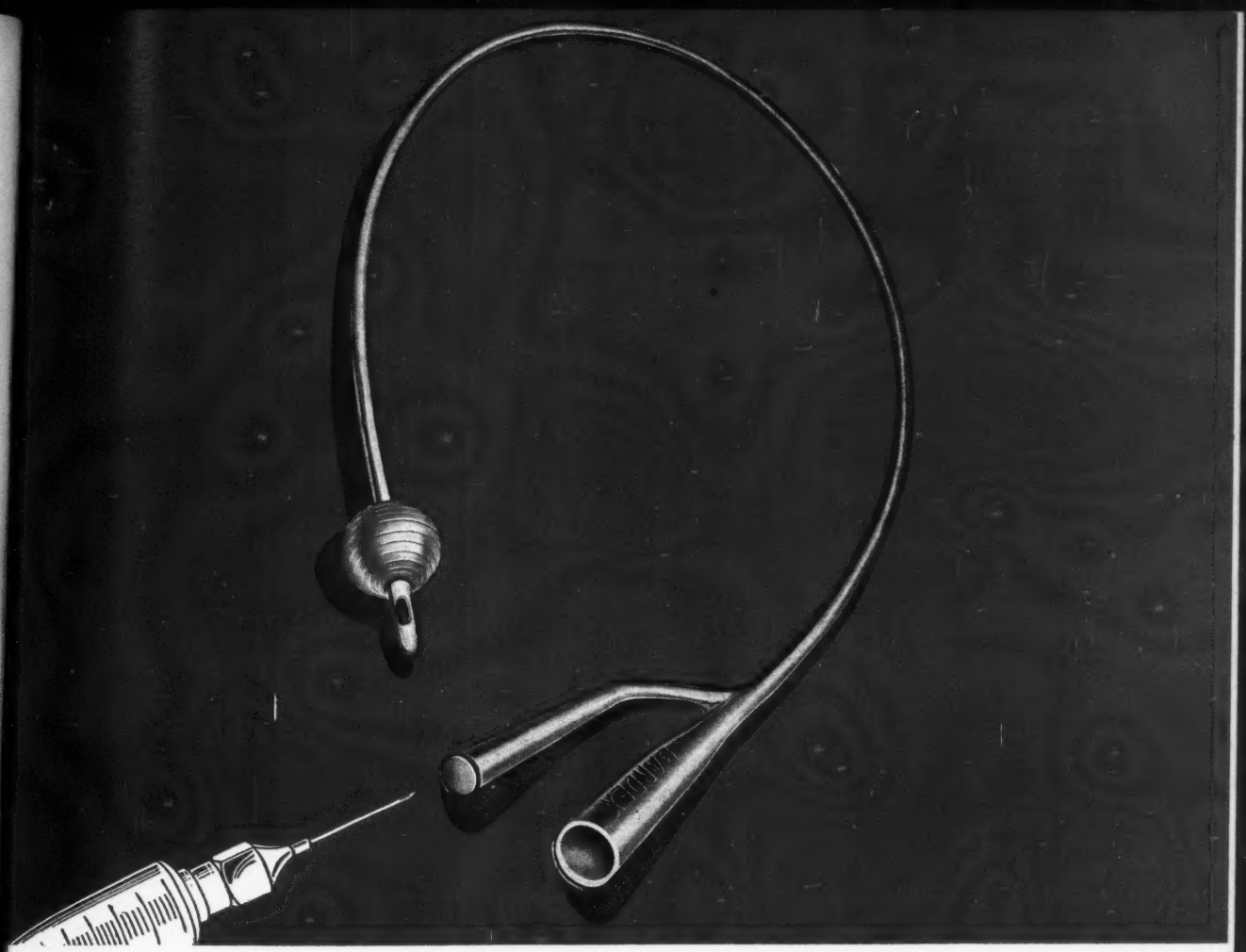
• • • •

Director of Nursing at the Queensway General Hospital, Toronto

A graduate of the Toronto Hospital for Sick Children School of Nursing, Dorothy G. Hollister has been appointed director of nursing at the new Queensway General Hospital, Toronto, Ont. Miss Hollister took post-graduate studies in obstetrics at Women's College Hospital, Toronto, and later in administration of nursing service at the School of Nursing, University of Toronto. She was director of nursing at South Waterloo Memorial Hospital, Galt, Ont., prior to accepting the position at the Queensway. Miss Hollister has been superintendent of Douglas Memorial Hospital, Fort Erie, and the Great War Memorial Hospital in Perth, Ont. She was assistant to Rhano Beamish, administrator and director of nursing at Sarnia General Hospital, Sarnia, Ont. While in Sarnia, Miss Hollister

Dorothy G. Hollister

(Continued on page 20)



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with Self-Sealing Plug in Inflation Funnel

ONE PERSON can easily inflate and deflate this Gilbert type BARDEX Foley Catheter. No assistant is needed to clamp or tie off the inflation funnel.

Using a syringe with a 1 inch 20 gauge needle, the plug is easily punctured. Then the balloon is inflated to the exact size desired with a measured amount of water.

When the needle is withdrawn, the plug is self-sealing. There is no drip after inflation or deflation. To deflate, merely puncture plug with needle on empty syringe.

More and more hospitals and physicians are saving time and money by using this Gilbert Type BARDEX Foley Catheter.

C. R. BARD, INC.
SUMMIT, NEW JERSEY

Notes About People

(Continued from page 16)

was secretary-treasurer of District No. 1, Registered Nurses' Association of Ontario. This is the first time that Miss Hollister has been "in on the ground floor" of hospital planning and construction.

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Kitchener-Waterloo Appointment

Francis B. Gadsby, business manager at the Kitchener-Waterloo Hospital, Ont., since 1953, has been appointed assistant administrator. Mr. Gadsby has also been associated with the accounting department of the Hospital for Sick Children, Toronto, Ont. He is a graduate in economics of the University of London (England) and has recently completed the extension course in Hospital Organization and Management sponsored by the Canadian Hospital Association.

• • • •

At McKellar General Hospital

Mr. John Kunetsky has been appointed office manager and accountant at McKellar General Hospital, Fort William, Ont. Mr. Kunetsky is a graduate of the 1954 extension course in Hospital Organization and Management sponsored by the Canadian Hospital Association. He was formerly administrator of the Sioux Lookout General Hospital, Sioux Lookout, Ont.

Noreen Malleck

New Pharmacist at Guelph

Noreen Malleck, a pharmacy graduate of 1954, specializing in her last year in hospital pharmacy, has been appointed pharmacist at the Guelph General Hospital, Guelph, Ont. Miss Malleck replaces Mrs. Peggy Willoughby who has been pharmacist for the past two years.

• • • •

Canadian Appointed at Chicago

Norman A. Brady has been appointed as one of two assistant directors of the recently merged Presbyterian-St. Luke's Hospital, Chicago, Ill., which will be located in the midst of the growing west side medical centre. He will continue to serve as administrator of the Presbyterian Hospital. Mr. Brady has been in hospital work since 1946. He was business manager of the Queen Mary Veterans Hospital, Montreal, P.Q., and also of the Sunnybrook Hospital, Toronto, Ont., prior to joining St. Luke's in 1953. He is a member of the American College of Hospital Administrators, American Hospital Association, and the Hospital Club of Northwestern University.

• • • •

From O.H.A. to O.M.A.

It was announced recently that George Ferchat has been appointed

(Concluded on page 78)

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

The Hospital Pharmacy

WHETHER YOUR hospital is large or small, caring for short-term or long-term patients, one of the departments which is vital in good patient care is the hospital pharmacy. During the past decade, the construction of many new Canadian hospitals and the expansion of existing institutions have called for many additional personnel of all types. At present, one department where qualified personnel are in short supply is the hospital pharmacy.

The importance of the hospital pharmacy department is becoming more and more widely recognized. Evidence of this is indicated by the growth of the Canadian Society of Hospital Pharmacists since its inception almost ten years ago. Now there are branches of the society covering all provinces. Also, courses specializing in hospital pharmacy are available at three Canadian universities. In January 1956, the hospital pharmacy was recognized as an essential department for accreditation under the standards set by the Joint Commission on Accreditation of Hospitals.

During 1955 and early 1956, H. J. Fuller, professor of pharmacy administration, and Isabel E. Stauffer, special lecturer in hospital pharmacy administration, both of the Faculty of Pharmacy, University of Toronto, undertook an extensive survey of hospital pharmacy practice in Canada. The results of this survey will be published in two parts, commencing on page 38 of this issue. The authors submitted a questionnaire to 673 Canadian hospitals and received replies from 349; 168 of the 199 hospitals which employ a pharmacist supplied the information which is tabulated in the accompanying tables. Returns were received from all Canadian provinces, the Yukon and North West Territories.

A study of the survey reveals many interesting and some unexpected facts. The tables portray staffing patterns on a statistical basis—the distribution, proportion of male and female, and the number of pharmacists employed in short-term and long-term hospitals per number of beds, salary schedules, work loads, and other features. The number of hospitals not employing a pharmacist, and hospital pharmacy practice in the various provinces will be discussed in Part II of this article.

One of the results of the survey is to show that of the 673 hospitals approached, only 199, or 29.5 per cent employ a pharmacist. While it is understandable that small hospitals in most cases will rely on the services of a retail pharmacist for their dispensing needs, the survey was directed at hospitals over 50 beds in size. As the article points out. "In the majority of 50-bed hospitals of the same type, the employment of a part-time pharmacist is feasible."

However, it is to be remembered that the interpretation of information received from questionnaires in general is not an easy task; and no matter how careful one is in drafting the questions, the interpretation of the question will show a wide variation in the answers received.

We are indeed indebted to Professor Fuller and Mrs. Stauffer for this original article, the preparation of which involved much hard work extending over many months. Those hospitals who participated by answering the questionnaire will now have an opportunity of seeing the results of their co-operation. To all hospitals, large or small, we believe the survey will be informative and interesting.

Does Hospital Care Cost Too Much?

IT IS stated on page 74 of *Hospitals in Canada*, General Series, Memorandum No. 10, published by the Research Division of the Department of National Health and Welfare, that since 1946 the rise in operating expenditure of public general and allied public special hospitals has been extraordinary. In 1946 the figure was $5.16 per day and, in 1953, the cost was $11.29, an increase of 119 per cent. The author states that the main causative factor was price inflation. Like all other segments of the national economy, hospitals have been forced each year to spend increasingly large sums of money to obtain the same goods and services. Another factor has been the great expansion of special facilities and specialized personnel, enabling better diagnosis and treatment.

The public is becoming more conscious of the cost of hospital care. This is understandable since more people every year enter hospitals as patients, and more people are covered by some form of hospital insurance — whether it is through a premium in a Blue Cross plan, an insurance company, or payments to a provincial government hospital insurance plan. Those who complain about the cost of providing hospital care today do not take into consideration the cost of other commodities and services at the present time. It is within the memory of all of us when three cents would buy a newspaper and send a first class

letter almost anywhere; five cents would buy a good sized candy bar, an ice cream cone, or a bottle of pop; $1,000 would buy a very good new car; and $5,000 to $6,000 would provide you with a home which now costs three of four times as much.

One sometimes hears hospital and hotel rates being compared. The charge made by a hotel covers sleeping accommodation involving a bed in a furnished room. Extra services utilized are paid for at an additional cost. On the other hand, the hospital provides in the daily charge all the ordinary services provided by a hotel, plus meals and personal nursing service around the clock, which varies according to the patient's needs. In a hotel you pay for one day's lodging. As pointed out in the booklet, *Hospital Costs*, published by the Ontario Hospital Association, it is well to remember that in a hospital you receive three working days of scientific care every 24 hours.

The hospital's charges for room and board do not by any means represent the over-all cost of the hospital services to the patient. Hospitals actually have little control over the utilization of special services beyond making them available. This is a point which does not seem to be very well understood by patients in general. The type and amount of service used by any patient is determined by his family physician. The doctor orders what he deems necessary for diagnosis and treatment and the hospital staff carry out his instructions.

To those who enquire when hospital costs will level off, the answer is only when, in the general economy, we reach a stabilization of salaries and wages and a halt in the rising cost of all supplies. We live in an era of mass production, mechanization and automation. The use of the media of mass production has enabled us to have a higher standard of living and a shortening of the general work week in the community. While many of the assembly-line methods used so successfully in reducing unit costs in industry cannot be applied to bedside care and other personal services, hospital workers are entitled to share in the general shortening of the work week. During the past decade we have seen the hospital work week decrease from 48 to 44 to even 40 hours a week, and sometimes less. We have seen the introduction of the five-day week for many workers; the 12-hour shift has disappeared completely.

Whenever anyone alludes to the "good old days" today, they mean in general the depression era of the 30's, but a moment's reflection should convince us that none of us want those days to return. Those were the days when graduate nurses worked for $50 a month or less, and often could not secure regular employment even at that figure; when the supervisory staff were on a 12-hour shift, and student nurses likewise. Those were the days when work was very scarce and, for many university graduates and others, unobtainable. Those were the days, too, when even at a low rate for hospital care, many people could not pay public ward rates. Those were the days also when many people lost their homes because they could not keep up their payments. No, there was nothing good about those good old days.

In considering today's hospital costs, boards of trustees and administrators have to keep two main objectives before them constantly. One is that they satisfy themselves that their hospitals are being operated economically on a business-like basis, and, secondly, that they do not have in 1956 the monetary values of the 1930's because values have changed markedly. Employees receive in cash remuneration much more for the same service today than they did for the same service in 1930. A dollar today does not go nearly as far as it did in that era, but there are more dollars; more dollars earned and more spent.

As pointed out in Memorandum No. 10, there have been other factors at work besides one of general inflation. The shortening of the average length of stay has been continual. Shorter stay means more intensified care while the patient is in the hospital, and therefore the unit per diem cost is bound to be higher. What about the over-all cost for any given illness, say pneumonia or appendicitis? In some diseases it can be shown that, even with the inflationary spiral, it is actually less than it was with the much longer care given for any specific disease two decades ago. These factors are such that it is questionable if it is good policy for any hospital to quote cost on a per diem basis today.

These facts are usually understood by hospital people. However, they need to be pointed out at every opportunity to the public. In telling our story it must not be forgotten that hospital care is something no one wants to buy.

L'Accréditation Intéresse Tout Hôpital

LE SUJET d'accréditation paraît souvent ces jours-ci sur les programmes d'assemblées et d'instituts, et aussi sur les pages de journaux hospitaliers. Cependant, les représentants d'hôpitaux de moins de 25 lits disent souvent que l'accréditation n'a pas d'intérêt pour eux, étant donné qu'on n'examine que les instituts ayant plus de 25 lits. Les administrations des petits hôpitaux, qui ont le nombre de lits requis, jugent souvent que leur système d'organisation du personnel ne leur permettrait pas d'être accrédités.

La plupart des petits hôpitaux éprouvent des difficultés à organiser leur personnel médical. Ceci est très évident ou il n'y a que deux ou trois docteurs membres du personnel hospitalier.

On a beaucoup discuté ce point, en 1955, à l'Institut du Canada de l'ouest pour administrateurs et gouverneurs d'hôpitaux. Une des questions particulières qu'on a posée était: Comment organiser quand il n'y a qu'un docteur pour tout l'hôpital? Ce n'était pas une question inutile pour les hôpitaux qui s'y intéressaient. Le cas n'était pas isolé, car il représentait l'expérience de nombreux hôpitaux. Pourrait-on exiger d'un seul médecin qu'il prenne la responsabilité de tous les postes inclus dans l'organisation d'un personnel médical et qu'il soit au service de plusieurs comités? Que ces hôpitaux jugent avoir ou n'avoir pas reçu une réponse satisfaisante à cette question, ils seront heureux d'apprendre qu'un hôpital en Alaska, dont le personnel ne comprend qu'un médecin, a été entièrement approuvé par la Commission Mixte d'Accréditation des Hôpitaux. Ce cas devrait inciter ceux dans les hôpitaux de 25 à 50 lits, ayant un personnel réduit, à essayer d'atteindre l'accréditation.

Le programme d'accréditation, suivi longtemps par le Collège Américain des Chirurgiens et suivi maintenant par son successeur, c'est à dire, le programme de la Commission Mixte, continue l'amélioration des hôpitaux et des soins médicaux de l'Amérique du Nord. Le programme d'accréditation des hôpitaux représente une quantité de choses, mais il est surtout un programme d'éducation. Alors qu'il est vrai que les hôpitaux ayant moins de 25 lits ne sont pas examinés, ceci ne veut pas dire que de tels hôpitaux ne peuvent pas profiter du programme. Les gouverneurs, les personnels médicaux, et les administrateurs de petits hôpitaux, tous s'intéressent à l'amélioration du soin des patients. Les hôpitaux qui utilisent les imprimés disponibles qui traitent de l'accréditation, pour les adapter à leur propre cas, trouveront que l'hôpital et leurs patients en tirent grand profit.

What of the Future?

J. Gilbert Turner, M.D., C.M., F.A.C.H.A.

President, Canadian Hospital Association
Montreal, P.Q.

THE advances in medical and surgical care, the longer span of life, the tempo of life today, the growth of prepaid hospitalization plans and the acute shortage of competent staff at many levels are dictating changes in hospital care and in hospital management, with the result that we must give the closest attention to certain matters of very great importance now and for some time to come.

Accreditation of Hospitals

The standards of the Joint Commission of the Accreditation of Hospitals, formulated by trustees, doctors and administrators from both the United States and Canada, and based on the approval standards of the American College of Surgeons, impose upon our doctors the formal tasks of self-appraisal and self-discipline. This is as it should be.

The same standards have also imposed certain very definite responsibilities upon hospital trustees and administrators. The whole concept of this program is aimed toward the protection of the patient. In spite of argument—in some quarters very vociferous—to the contrary, it is quite unthinkable that these standards should be discarded, or that their implementation be the responsibility of only one of the present participating bodies of the Joint Commission. We in Canada took the proper step in these early stages of the life of the Joint Commission in co-operating with our friends from the United States, but it is not unreasonable for us to look forward to the day when we will have a completely autonomous Canadian Commission on Accreditation of Hospitals. Meanwhile, it is our duty to support the present program of accreditation in every way possible and, more important, to see that all concerned within our hospitals pay it more than lip service.

Personnel Policies

A recent poll of some 3,000 employees representative of many industries as to their opinions on certain personnel policies, and a concurrent poll of their employers as to their knowledge of their employees' feelings towards the same policies, showed some striking differences of opinion between employees and employers.

In answer to the question, "What do you rank as the most important factor on the job?", over 70 per cent of the employees replied, "Credit for work done and appreciation of my services by my employers". The majority of the employers ranked this seventh as their opinion of how employees felt.

Number two in importance to the employees was, "Interesting work, interesting surroundings and interesting people to work with". Employers rated this factor third in their list. Employees rated pay as third in importance while employers put it first. Job security ranked eighth with employees and with employers, second.

In your own hospital, what is the annual rate of turnover of personnel? Is it 25, 50, or 100 per cent? What is the wastage due to turnover costing each of our hospitals every year in hard dollars and cents?

Our personnel policies must be more in line with those of industry and business at the local level, while in return we must insist upon a high level of performance. The five-day week is a growing movement in hospitals. Salaries are better, but in certain areas there is need for improvement. Contributory plans for prepaid hospitalization, for pensions and for group insurance are rapidly becoming the rule in hospitals. Working conditions and personnel comforts—such as attractive offices and adequate rest room space—must be improved if we are to recruit and hold competent people. Our personnel policies do not have to be extravagant—they do need to be realistic, and to be respected by the community.

J. Gilbert Turner

Public Relations

The good name of a hospital depends primarily upon the type of care its patients receive. Our doctors and nurses are key figures here—but there are others. A patient can have good medical and nursing care, yet be disturbed by the thoughtless act or careless word of one or several persons who contribute during his stay in hospital. The courteous greeting of the doorman, the helping hand of the elevator operator, the appeal of tastily prepared meals, all these and many others are most important in the total picture of patient care. We as administrators must see to it that all these influences make for the best; they necessitate eternal vigilance, but it is part of our job to instil into the members of the hospital family the concept of team effort in patient care. All must remember that the efforts of one group are supplemented by the efforts of other groups and that, no matter whether the individual's place in the organization chart be high or low, he has a job to do which is necessary for the total job to be done properly. Good public relations begin within the hospital and their success is in direct proportion to the will and effort put into them by every member of the staff, regardless of rank. Good public relations are developed by staff effort; they are not attained merely by writing about them.

One cannot leave the subject of Public Relations without acknowledging in a very sincere way the women's auxiliaries and the volunteers as a very great force in furthering the good cause of any hospital. Both these groups are growing rapidly in numbers and in influence. They can be just as helpful in the small hospital as they can in the very large one.

Business Procedures

We must continually study methods used in business and industry and borrow from them the best that can be fitted wisely into the scheme of pa-

An address at the Annual Banquet of the Maritime Hospital Association, St. Andrews, New Brunswick, May 30, 1956.

tient care, for example: the embossographing of patient identification data and electronic machines for payroll, accounts payable, inventory control and patient statistics. Further studies are necessary to determine the minimum patient load necessary to make the installation of highly mechanized equipment desirable. We are living in an age of mechanization undreamed of a few short years ago and it is up to us to keep abreast of the times, not only in the business office but also in the various service departments. I cannot help but add, in view of the extreme shortage of capable stenographic and typing personnel, that we must hope it is within the realms of practicability that the dictated word through electronic means will appear in record time as the perfect typed letter or report.

Nursing

The shortage of nurses will continue until all acceptable training schools have their quota of students and until all wards now closed, or not yet opened because of lack of nurses, are in full use. More nurses are being trained than ever before—but the demand is far greater than ever before. Without prejudice to good patient care, we must relieve the nurses of all work such as dietary, clerical, and messenger that can be just as well—and even better—handled by others. Administrative and supervisory nursing positions can only be filled adequately by those of ability, experience and advanced training, and for this reason we need schools of nursing at the degree level. The traditional three year course for the training of nurses is subject to much study and experimentation these days, and what the final answer will be is still a matter of conjecture. If we are to ask our nurses to keep pace with the rapid advances in medical care, it hardly seems possible to reduce to any great degree the present academic requirements of the course. There appears to be much merit in concentrating on the teaching and lectures in the first two years, thus leaving the third year free for bedside nursing.

More than one study has shown that the cost of training a student nurse exceeds by some two or three hundred dollars a year the dollar value of the service she gives in return, and there is at the moment no one but the patient to make up this differential. Requests for training grants-in-aid to hospitals for their schools of nursing are, therefore, quite legitimate. On the other hand, the need for financial assistance, either by bursary or loan, to enable many of our most acceptable applicants to study nursing, has been amply demonstrated.

While the number of auxiliary nursing personnel has increased tremendously in the past ten years, further encouragement must be given to the training of even larger numbers to an officially-recognized standard. We need very much the male members of this group, the orderly or the attendant, whose job stature has greatly increased.

The recruitment of nurses is everybody's business and not just that of the director of nursing. Members of the medical profession should be amongst the first to encourage young ladies to take up training, for they and their patients are the first to suffer from a shortage of nurses. Nurses themselves and women's auxiliaries are powerful forces as recruiting officers, as also are school teachers and high school counsellors.

There must be continuing studies to point out ways in which the nurses' talents may be used to the best advantage. A good example is the recovery ward. Every hospital that is big enough to have an operating room is big enough to have a recovery ward. It should have a recovery ward where all the facilities of the hospital can be brought into action immediately if the occasion arises in the critical post-operative period. If we do it in surgery, why not an immediate post-partum room? If we do it for surgery, why should we not do it for medical cases? Why not have a small active treatment ward, or two if you will, one for each sex, adjacent to and in full view of the nursing station and equipped with every necessary item? Why disperse acutely ill medical patients throughout a ward when they would be much safer in one large active treatment room? We should break down this present financial barrier of public, semi-private and private distinction and treat the patient for his medical condition—and not according to his pocket-book. As a matter of fact, I feel that the day will soon come, if it is not already here, when group treatment such as the recovery ward, the post-partum ward, and the active treatment units will supplant the individual system in the interests of patient welfare and the efficient use of available medical and nursing talents.

Others

We shall see greater development of the Home Care programs for selected cases, bearing in mind that this successful and much-less-costly technique of patient care is applicable to only about 15 per cent of those with long-term illness.

Diagnostic Services will take their rightful place as a sensible means to overcome the present utter waste of everyone's time and money and of expensive specialized facilities for in-patient care.

Psychiatric Divisions in general hospitals will be established at an even greater rate as trained staff becomes available. The Day Hospital and Evening Hospital concepts will be more accepted as a reasonable method of providing medical care to the ambulatory patient at less cost and without depriving him of his livelihood or the comforts of home. The hospital will become more of a Community Centre. While its primary purpose will be for in-patients, it will have full diagnostic services, means for all ambulatory care, both day and evening, as well as emergency service twenty-four hours of the day. It will house the special public health clinics and it is reasonable to say it will house offices for its attending doctors. The large university hospital will be the parent institution to one or more smaller hospitals outside the city, not only for the reception of patients needing special care but also as a base from which consultants may be available, from which interns will rotate for experience in general practice and at which nurses may get part of their training.

Rehabilitation

A recent regional survey of general hospitals showed that of all patients some two per cent were suffering from long-term illness, and that they accounted for 20 per cent of the patient days and for about 16 per cent of the total cost of hospitalization. This state of affairs is most wasteful of expensive construction and facilities designed especially for the acutely ill; worse still, is the realization that many of these long-term patients have not had the advantage of rehabilitation measures. We must give a great deal more study, and soon, to the problems of rehabilitation. In the interests of patient welfare and the national economy we must be prepared to find the means to implement sound programs for the benefit of all patients of all ages, whether suffering from injury or disease, for whom there is even the slightest hope of some measure of return to gainful employment or to a better way of life. Allied with this problem is one just as severe—and that is the provision of proper facilities for the care of the chronically ill who, after thorough appraisal, could not hope to benefit from a rehabilitation centre. These people must be taken out of the acute general hospital for many obvious reasons, even though it means imposing a greater burden on that hospital in looking after a population of acutely ill patients.

(Concluded on page 80)

Bed needs among hospitals under general insurance

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WITH the extension of various programs of hospitalization insurance, both governmental and voluntary, there is wide interest in reappraising the needs of a population for general hospital beds. With elimination of all or a large proportion of financial barriers to hospital care, old conceptions of the proper supply of beds for a community — conceptions based on individual rather than collective financing of hospital care — change rapidly. Under insurance or public financing, the demand for hospital care rises so steadily that one might almost gain the impression that the demand is unlimited, and that if any number of additional beds are built, they will indeed be occupied.

Total Hospital Bed Needs

There is, however, a limit to the general hospital beds properly needed by a community, even with all financial deterrents removed. The determination of this limit has been a matter of study in this and other countries for many years and, in September, 1953, Louis S. Reed and Helen Hollingsworth published a very useful summary of U.S.A. and Canadian estimates up to that time.[1] They concluded, on the basis of combined studies, that in average United States conditions 4.4 to 4.7 hospital beds per 1,000 people were needed for diagnosis and active treatment of general illness, and an additional 2.3 to 2.6 beds per 1,000 for chronic illness and convalescence. Combined needs for acute and long-term care, therefore, were estimated as between 6.7 and 7.3 hospital beds per 1,000 or, let us say, about 7.0 beds per 1,000 persons.

Experience in Saskatchewan, since the inauguration of the Hospital Services Plan in 1947, suggests the need for a greater number of general hospital beds for acute and chronic illness under the conditions found in this highly rural and thinly settled province. In 1951, the Saskatchewan Health Survey Committee estimated that 7.5 beds in general hospitals were needed to meet total needs,[2] and subsequent experience has borne this out with remarkable closeness. During the past five years, 1950-1954 inclusive, after a rapid initial rise, hospitalization rates in Saskatchewan have levelled off at a plateau of about 200 cases and 2,150 days per 1,000 persons per year.[3] This volume of hospital care requires 5.9 occupied beds per 1,000 persons. If it is assumed, according to widely-held standards, that on the average day not more than 80 per cent of a hospital's beds should be occupied, then it follows that 7.4 beds are needed to accommodate this volume of patients.

The principal purpose of this article is to present a formula developed from the Saskatchewan experience, by which the current bed needs of a particular institution in a province may be estimated — a matter of pressing importance in day-to-day administration of hospitalization insurance. This formula rests on an assumption, namely, that 7.4 (or to be generous 7.5) beds per 1,000 persons is adequate to meet needs, yet not too high a figure. Leaders in other provinces or states where the supply of beds is much lower (the U.S.A. average in 1951, for example, was 4.2 general non-federal hospital beds per 1,000 people) may claim that this supply is extravagantly high. Saskatchewan hospital boards, on the other hand, faced with demands for beds, may claim it is too low.

Determinants of Saskatchewan's Supply of Beds

The facts in Saskatchewan are that, taking the province as a whole, hospitalization needs are apparently being well met with a volume of 2,150 days per 1,000 persons per year. Among our 163 hospitals, the few large ones have short waiting lists but, on the whole, there is high flexibility in bed complement. Demands for more beds are nearly always met by setting them up — far exceeding the measured capacity of the institution in many instances. Moreover, if one hospital is filled at a given time, there is an unimpeded flow of cases to another hospital nearby or at a distance. Between 1944 and 1950, hospital capacities expanded rapidly in Saskatchewan. Even though the aggregate measured capacity (according to federal standards of 100 square feet per bed, et cetera) is under 7.4 beds per 1,000 therefore, there is little reason to believe that physical size has placed any rigid ceiling on hospital use in the province in the past few years. The fact is that, according to our latest data, the complement of beds actually available in Saskatchewan general hospitals (excluding Indians for whom there are special federal facilities) is now at a level of 7.4 beds per 1,000 population.

On the other hand, is a volume of 2,150 patient days per 1,000 each year excessively high? This is a very complex question and it can only be stated that conditions of life and of medical service in Saskatchewan seem to require this level. The system of payment, developed during the first four years of the Hospital Services Plan, by paying hospitals mainly for their "readiness to serve" rather than on a patient-day volume basis, removed any financial incentive to hospital managements for high admission rates or long stays.[4] Even within the province, however, there are large differences in the rates of admission and total days of care experienced by residents of different communities. Studies reported last year suggested that higher admission and hospital-day rates are found in areas of greater rurality.[5] Rates are higher in the small towns, villages, and hamlets than in the cities. Within rural districts, rates are higher where the value of the land is lower and the density of the population less. Admission and day rates are higher where there is a smaller relative supply of doctors and where persons live at a greater distance from the large cities. While the evidence is indirect, there is every suggestion that hospital utilization is higher among people whose housing is poor and who do not have ready access to good diagnostic and treatment services on an ambulatory basis. Compared with other provinces having greater industrialization and higher urban concentrations of population,

From an address presented at the annual meeting of the Saskatchewan Hospital Association, 1955.

For references see page 92.

these social and professional factors, yielding high hospital usage, characterize Saskatchewan as a whole.

There are other factors beyond these and beyond the hospital insurance plan which may account for high demand for hospital care in Saskatchewan. Rurality, in general, is associated with a high birth rate and, with nearly all Saskatchewan births hospitalized, more maternity admissions per 1,000 occur than in more urbanized provinces like Ontario, Quebec, and British Columbia. During the 1935-45 decade there was heavy migration of young adults, so that the resultant age composition in Saskatchewan is higher than the Canadian average for the older age groups, among whom sickness experience is greater than average. Then, in Saskatchewan there is a great deal of insurance for medical and surgical care. About 50 per cent of the population are covered by governmental or voluntary schemes which pay doctor bills. As in experience with Blue Shield and Blue Cross plans in the United States, this collective financing further reduces economic obstacles and heightens the tendency to use the hospital, compared with private fee-for-service medical relations. (There is unfortunately little evidence that early medical care in the office and home reduces hospital use. If it has any such effect, it seems to be more than compensated for by a resultant detection of illness or anatomical defects, leading to hospitalization, in higher frequency than under private, non-insured doctor-patient relationships.)

In summary, then, Saskatchewan conditions seem to produce a province-wide need for about 7.5 hospital beds per 1,000 persons. It should be added that this does not count an additional 1.0 to 1.5 beds available in nursing homes and custodial institutions for the aged and chronically ill operated by public and private agencies throughout the province. A substantial share of the 2,150 patient days in general hospitals, indeed, is consumed by long-stay cases. (The 4.8 per cent of admissions remaining over 30 days utilize 31.4 per cent of the total patient days of care.) But under present conditions, these patients can be provided for best in general hospitals.

Distribution of Beds Among Different Hospitals

On this foundation of 7.5 beds per 1,000, how can decisions be made on the proper number of beds in any particular hospital, among the 163 units serving Saskatchewan? In hospital insurance administration, this decision becomes extremely important—especially under conditions where, as in Saskatchewan, well over 90 per cent of in-patient accounts are covered and, moreover, where the system of payment is based on the supply of beds in "readiness to serve" or the fixed costs of hospitals. In other words, each hospital is provided a periodic sum of money (semi-monthly in Saskatchewan) which approximately meets its fixed operating costs — salaries, fuel, depreciation, et cetera — and then a much smaller sum, roughly sufficient to meet the variable operating costs, *e.g.* food and drugs, which will vary directly with the exact number of admissions. The size of the fixed cost payments is determined by the number of patients expected to occupy the hospital on the average day of the year, considering the needs of efficient operation and proper quality of care. This number of patients for each hospital in Saskatchewan we describe as its "Recommended Occupancy". Recalling that good hospital operation requires that on the average only 80 per cent of the beds should be occupied, this number is ideally 80 per cent of the *bed need* of each hospital. Thus, a determination of the proper bed need of each hospital directly influences the payments that hospital receives from the Saskatchewan Hospital Services Plan.

If 7.5 beds per 1,000 persons is conceived as a great hospital pie, the task is to divide the pie among the province's 163 institutions in a way that is equitable, yet meeting fairly varying conditions of life and medical service in different communities. Our approach attempts to strike a balance between empiricism and rationalism — empiricism as shown by actual patterns of hospital use by the people, and rationalism as reflected in modern concepts of hospital regionalization.

Population Served by Each Hospital

Each of Saskatchewan's 163 general hospitals serves a particular population. These people, of course, reside predominantly in the immediate vicinity of the hospital but an appreciable number of them come from varying distances away. The proportion of patients coming from great distances — that is, within the immediate vicinity of another hospital — tends to be greater for hospitals of larger size.

Before experience was available from the operation of the Hospital Services Plan, it was necessary to make certain assumptions about the exact proportions of patients coming to a hospital from varying distances. Using the concept of hospital regionalization, developed a half century ago in Scandinavia and formulated in recent years on this continent, it was assumed that a province like Saskatchewan has four classes of hospitals of increasing technical complexity: community, district, regional, and base institutions. The geographic span of each of these types of hospital increases in that order, commensurate with the size and technical resources of each type. Thus, it has been assumed that the people in any community would be served by 4.5 beds per 1,000 in the nearby community hospital, by an additional 1.0 bed per 1,000 in the district hospital, by a further 0.5 bed per 1,000 in the regional hospital, and by a still further 1.5 beds per 1,000 in the base hospital. These criteria were a useful guide to initial planning, but they are obviously crude and subject to endless variations in practice, according to the degree to which each hospital fulfills its theoretical role, the conditions of transportation, and the personal choices of the people as to doctors and hospitals.

With the accumulation of several years of experience of the Saskatchewan Hospital Services Plan, calculations of the actual flow of patients to different hospitals — and hence the populations served by these hospitals —can be made with much greater accuracy. S.H.S.P. records tell us the place of residence of each patient using each hospital during the year. Then the number of patients from community *C*, for example, using hospital *h* can be related to the total number of patients from community *C* using all hospitals that year. This fraction may then be simply applied to the total resident population in community *C* and it can be concluded that this *number of people* from community *C* are theoretically being served by hospital *h* (as distinguished from hospitals *j. k. l*). The same analysis is then carried out for communities *D, E, F,* and all other communities contributing any significant number of patients to hospital *h*. When these numbers are added together, we derive a figure for the theoretical *total apportioned population* from anywhere in the province being served by hospital *h*. A similar calculation is then made for hospitals *i, j,* and all the rest.

The next question is how many beds

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does this apportioned population need in hospital *h*? It will be recognized that the total apportioned population is a theoretical figure since, in practice, many of these individuals using hospital *h* at one time for one illness will use hospital *i* at another time for another illness. It will be recalled further that the total needs of the entire provincial population — and therefore of the apportioned population of hospital *h* as well — can be met by a supply of 7.5 beds per 1,000. The share of these 7.5 beds per 1,000 of the apportioned population which must be provided in hospital *h* will be influenced by two factors: the average length of stay (days of hospital care per admission) in hospital *h*, and the frequency with which persons from this apportioned population seek care at any hospital (the hospital utilization rate of this population group).

Length of Hospital Stay

As bed needs are determined by the total number of days that patients occupy hospital beds, rather than merely the rate of admissions, it is evident that the average length of the stay per admission must be considered. The average length of stay in a hospital tends to be a characteristic of that hospital — or perhaps one should say of the diagnostic categories of cases served in that hospital — rather than of the apportioned population it theoretically serves. This figure for each hospital is easily calculated from S.H.S.P. admission discharge records. It is found that nearly all small community hospitals tend to have a short average length of stay, reflecting admission of less severe cases. The average length of stay increases quite consistently with the increasing size and more complex functions of district, regional, and base hospitals.

The provincial average length of stay in all hospitals over the past several years happens to be approximately 10 days. Insofar as the average length of stay in hospital *h* is above or below this provincial average, the need for beds in this hospital will be above or below 7.5 per 1,000 of its apportioned population. If the average length of stay in hospital *h*, for example, is 8 days, then its need for beds are reflected by 8/10 times 7.5 or 6.0 beds per 1,000 apportioned population. On the other hand, if the length of stay in hospital *h* averages 12 days, then its needs are for 12/10 times 7.5 or 9.0 beds per 1,000.

The average length of stay in a given year may be unduly influenced by the habits of a particular doctor in the local community that year or the hospitalization of a few very long-stay cases. Moreover, there may be peculiarities for several years in the practices of a particular hospital, compared with other hospitals of the same size and functional character. To adjust for these variations—and at the same time to encourage in some degree reasonable practices under the regionalization concept — the average length of stay assigned to each hospital is based on experience over the past three years (rather than a single year) and derived from the data of a *group* of hospitals within a particular size-range —for example, 30-44 beds, 45-79 beds, et cetera. This is the average length-of-stay figure used in calculating the bed needs in each hospital.

Frequency of Hospital Utilization

The second factor influencing the ratio of 7.5 beds per 1,000 apportioned population of a particular hospital is equally important, namely, the frequency of hospital utilization of this population. This apportioned population, it will be recalled, comes from communities *C, D, E,* and the frequency of hospital care needed by

(Continued on page 60)

Table I

Determination of Hospital Bed Need

(Sample Calculation)

Over-all Supply of Beds to be Provided

On basis of experience, total needs in all hospitals require 7.5 beds per 1000 population.

Calculation of Apportioned Population Served by this Hospital.

Place of Residence	Discharged Hospital Cases: Total from Locality	Discharged Hospital Cases: Number served in hospital	1953 Covered Population of Locality	Population Apportioned to Hospital*: Cities	Towns	Villages	Rural
Rural Municipality							
A	437	34	2,367				184
B	459	105	2,015				461
C	429	48	2,310				258
D	498	255	2,209				1,131
E	856	11	3,279				42
Village X	100	46	340			156	
Village Y	37	18	121			59	
Village Z	123	97	472			372	
Others, 5 cases or less**:							
Cities		6		34			
Towns		3			14		
Villages		12				51	
Rural		10					47
			TOTALS:	34	14	638	2,123

* *Based on proportion of total cases from each locality receiving care in hospital.*

** *Apportioned population computed on the basis of 1953 average case-rates for all cities, towns, villages and rural areas.*

Correction for Urban-Rural Composition of this Population.

	Apportioned Population	x	Urban-Rural Correction*	=	Adjusted Population
Cities	34	x	174/206	=	29
Towns	14	x	222/206	=	15
Villages	638	x	235/206	=	728
Rural	2,123	x	211/206	=	2,175
Total:					2,947

* *Province-wide average urban or rural admission rates as fractions of total provincial rate.*

Correction for Length of Stay.

Hospital has a measured capacity of 16 beds.
Average length of stay in hospitals of 16-20 beds equals 7.8 days.
Provincial average length of stay in all hospitals equals 10.5 days.

Correction for Non-Covered Population.

Total days of care in hospital equals 4,938.
Days of care covered by Hospital Services Plan equals 4,863.

Final Computation

$$\text{Bed Need} = \frac{7.5}{1000} \times 2947 \times \frac{7.8}{10.5} \times \frac{4938}{4863} = 16.7 \text{ beds}$$

Many interesting
and certain unexpected facts
revealed by

Hospital Pharmacy Survey

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IN CANADA, during the last five years, there has been an increasing demand for pharmacy personnel with specialized training and experience in hospital pharmacy practice. Two factors responsible for this development have been:

1. The construction of many new Canadian hospitals with pharmacy departments or the expansion of existing hospital facilities with enlarged pharmacies; and

2. The attention focused on this hospital service in discussions prior to the inclusion of the pharmacy or drug room as one of the essential services in the "Standards for Hospital Accreditation" by the Joint Commission on Accreditation of Hospitals.[1]

In 1951, the Faculty of Pharmacy, University of Toronto, established a course in hospital pharmacy administration as an elective in the fourth year of the Bachelor of Science course in pharmacy. To date 61 students have taken this course. However, to the best of our knowledge only 15 of these 61 students are now practising in hospitals.

During 1955-1956, the Faculty of Pharmacy, University of Toronto, undertook the following survey of hospital pharmacy practice in Canada to determine:

(a) Specific, up-to-date information concerning the activities, duties and remuneration of pharmacists employed in this branch of pharmacy, in order to utilize the services of more of these graduates in hospitals; and

(b) A complete picture of the opportunities for service in this branch of pharmacy to enable the Faculty of Pharmacy to recruit more students to enter hospitals as full or part-time hospital pharmacists.

(Charts showing these findings have appeared from time to time in the *Bulletin of the Ontario College of Pharmacy*, published by the authority of the Council of the Ontario College of Pharmacy.)

The type and scope of pharmaceutical service required by a hospital varies with the type of ownership and control of the individual hospital as well as with the type of patients treated by each institution. The length of the patients' stay in hospital is also a determining factor in the amount of pharmaceutical service demanded for adequate patient care.

In 1954, the number of hospitals in Canada totaled 1,398.[2] Of these, 1,009 were classified as "public hospitals"; *i.e.* hospitals not operated for profit, owned by lay corporations, religious organizations, municipal bodies, or the provincial government, and which admit all patients regardless of their ability to pay. "Private hospitals", those

Table I

Province	No. of Hospitals with 50 beds or more	Total number of Replies	% of Replies to No. of Hospitals with 50 beds or more	No. of Hospitals Employing a Pharmacist	% of Hospitals employing a Pharmacist to No. of Hospitals with 50 beds or more	No. of Replies from Hospitals employing a Pharmacist	% of Replies from Hospitals employing a Pharmacist to No. of Hospitals employing a Pharmacist
Alberta	48	26	54.1%	17	35.4%	16	94.1%
B.C.	59	37	62.7%	17	28.8%	17	100.0%
Manitoba	28	18	64.2%	10	35.7%	9	90.0%
N.B.	24	15	62.5%	8	33.3%	7	87.5%
Newfoundland	11	4	36.3%	1	9.0%	1	100.0%
Nova Scotia	41	24	58.5%	12	29.2%	12	100.0%
Ontario	234	134	57.2%	62	26.5%	62	100.0%
P.E.I.	6	2	33.3%	1	16.6%	1	100.0%
Quebec	178	56	31.4%	55	30.9%	28	50.9%
Saskatchewan	38	30	79.0%	16	41.0%	15	93.7%
Yukon /N.W.T.	6	3	50.0%	0	0.0%	0	0.0%
TOTAL	673	349	51.8%	199	29.5%	168	84.4%

Table II

Distribution of Hospital Pharmacists by Provinces

	Alta	B.C.	Man.	N.B.	Nfld.	N.S.	Ont.	P.E.I	Que.	Sask.	Total
MEN, Full Time	11	30	8	6	2	8	71	..	21	15	172
MEN, Part Time	4	1	..	..	..	..	1	..	1	..	7
WOMEN, Full Time	11	5	6	3	..	11	54	1	38	10	139
WOMEN, Part Time	..	1	..	..	..	..	1	..	..	..	2
								TOTAL			320

* *The authors are respectively professor of pharmacy administration, and special lecturer in hospital pharmacy administration.*

which ordinarily restrict their admissions to paying patients and which are operated by private individuals or companies, numbered 251. The remaining 138 institutions were operated by the federal government and included hospitals under the jurisdiction of the Department of National Health and Welfare, the Department of National Defence and the Department of Veterans' Affairs.

These 1,398 hospitals provided 186,562 beds for patient care and were scattered throughout the ten provinces, the Northwest Territories and the Yukon. The bed capacity of the individual institution varied from 4 to 1,418 beds. Public hospitals accounted for 164,490 beds or 88% of the total bed capacity of Canadian hospitals. Of these, 77,522 beds were located in 829 public general hospitals, treating a wide range of conditions, while 86,968 beds were located in 180 public special hospitals, which provided treatment for the more particular conditions of alcoholic, chronic, contagious, convalescent, mental and tuberculosis patients et cetera. The majority of public general hospitals were active treatment hospitals or "short-term" hospitals. Institutions for patients with long-term illness or any disability requiring medical care for more than sixty days were termed "long-term" hospitals.[3]

Standards for pharmaceutical service now in existence are predicated on the assumption that the services of at least one full-time hospital pharmacist are required in all short-term, public general hospitals of 100 beds and over.[4] "In the majority of 50-bed hospitals of the same type, the employment of a part-time pharmacist is feasible", if other administrative duties are undertaken by this employee, such as purchasing, et cetera.[5]

The Response

The 1955 *Canadian Hospital Directory* was carefully combed, province by province, and every hospital with 50 beds or more listed. A three-page questionnaire was mailed to the administrator of each of these 673 hospitals. The number of replies was encouraging but before the returns were tabulated, a separate listing was compiled of all hospitals of 50 beds or more, possessing pharmacists shown in the 1955 *Canadian Hospital Directory*. Three appeals were then addressed to the administrators of these hospitals, who, by our records, were listed as employing a pharmacist, and the total response was tabulated in Table I.

The response from hospitals employing a pharmacist was most gratifying. Replies were received from every hos-

Table III

Pharmacy Personnel*—Staffing Pattern**

	Bed Capacity***					
	50	100	200	500	750	1,000
Chief	1****	1	1	1	1	1
Assistant chief	0	0	1	1	1	2
Staff pharmacist	0	0	0	1	2	1
Intern	0	0	1	2	2	3
Secretary Stenographer	0	0	0	1	1	1
Cashier*****	0	0	0	1	1	1
Pharmacy helper-stock control clerk	0	0	0	1	1	1
Pharmacy helper	0	1	1	1	2	2

* Based on outpatient activity of approximately 70 prescriptions daily.

*** Add 1 additional pharmacist for each additional 70 individual outpatients' prescriptions dispensed daily above basic 70. If pre-packaging is in effect, ratio is higher.

**** Assumes 1 or more additional areas of supervision — x-ray services; central sterile supply; laboratory, purchase and supply activities; general administration.

***** If outpatient activity and hospital policy indicate.

** Based on normal workloads, including the following measurable and non-measurable factors:

1. Compounding and dispensing of individual outpatient prescriptions.
2. Ward and clinic (basket) issues.
3. Hospital-manufactured pharmaceuticals.
4. Time consumed in individual consultations with medical, dental and other staff members on drug therapy problems.
5. Teaching schedules — medical, dental, pharmacy interns, nurses, medical record librarians.
6. Preparation of extemporaneous sterile parenteral and surgical solutions of narcotics, antibiotics, etc.
7. Requisitioning and/or purchasing of supplies.
8. Maintenance of perpetual inventories.
9. Preparation of reports, monthly, annual, on stock control of inventories, drug costs, workloads.
10. Attendance at and participation in staff, pharmacy committee and other meetings.
11. Clinical-pharmaceutical research.
12. Indoctrination and training of department personnel.

Table IV

Short-Term Hospitals—Distribution and Personnel

	50 to 99 beds (11)	100 to 149 beds (14)	150 to 199 beds (26)	200 to 399 beds (11)	400 to 499 beds (34)	500 to 1,000 beds (21)	Over 1,000 beds (3)
Distribution —Hospitals							
Alberta	2	1	2	3	..	1	..
British Columbia	1	1	1	....	2	1	1
Manitoba	..	1	2	3	..	1	..
New Brunswick	..	1	1	1	2	..	..
Newfoundland	..	..	..	..	1	..	..
Nova Scotia	2	..	2	..	3	1	..
Ontario	3	6	13	2	15	9	2
P.E.I.	..	..	..	..	1	..	..
Quebec	1	3	2	2	6	6	..
Saskatchewan	2	1	3		4	2	..
Personnel Number of Pharmacists							
Men, Full-Time	3	6	17	6	34	29	20
Men, Part-Time	1	..	..	1	..	..	..
Women, Full-Time	7	10	13	9	21	62	1
Women, Part-Time	..	1	..	..	1	..	..
TOTAL	11	17	30	16	56	91	21

Short-term hospitals are those in which the patient's stay is of relatively short duration, that is up to thirty days, and which are used for active treatment cases.

Table V

Long-Term Hospitals and Federal Government Hospitals—Distribution and Personnel

	Long-Term (22)	National Defence (4)	National Health & Welfare (8)	Veterans (14)	Hospitals all types, employing only one pharmacist (92)
Distribution — Hospitals					
Alberta	3	..	1	3	7
British Columbia	3	..	5	2	7
Manitoba	1	..	..	1	6
New Brunswick	1	..	..	1	5
Newfoundland	..	..	..	..	..
Nova Scotia	1	2	..	1	7
Ontario	6	2	2	2	35
P.E.I.	..	..	..	3	1
Quebec	4	..	..	1	13
Saskatchewan	3	..	..	..	11
Personnel Number of Pharmacists					
Men, Full-Time	15	5	6	31	52
Men, Part-Time	2	..	2	1	..
Women, Full-Time	10	..	1	5	40
Women, Part-Time	..	..	..	..	..
TOTAL	27	5	9	37	92

Long-term hospitals are those in which the patients remain for periods of months rather than days, e.g. convalescent hospitals, or institutions for the chronically ill or mental diseases.

pital possessing a pharmacist in British Columbia, Newfoundland, Nova Scotia, Ontario, and Prince Edward Island. Hospitals in the other provinces replied as follows: Alberta 94.1%, Manitoba 90%, New Brunswick 87.5%, Saskatchewan 83.7%, and Quebec 50.-9%. With the exception of Quebec, these percentages represent every hospital but one in each province. Although only 349 of the 673 hospitals, or 51.8% responded to the questionnaire, a total of 84.4% or 168 of the 199 hospitals which employ a pharmacist, supplied the information tabulated in the following tables. These results, then, are indicative of the practice of hospital pharmacy in Canada today.

The co-operation of 349 hospital administrators from Newfoundland and Prince Edward Island to the Yukon which made this survey possible has been an exceedingly satisfying — even an exciting—experience.

Statistics often reveal unexpected facts. Undoubtedly most of us assume that women are in the majority among hospital pharmacists. Our survey reveals the opposite (Table II). Very few Canadian hospital pharmacists are engaged on a part-time basis, and 39.-7% of the total number are employed by hospitals in the province of Ontario.

Personnel

The services of the hospital pharmacy must be tailored to fit the functions, staff and organization of the hospital in which it is but one department for the professional care of the patient. The amount and variety of service demanded by a large teaching hospital will differ in many respects from that required by a hospital for chronically ill or mental patients, even though the bed capacity of the two institutions is the same. The type and number of pharmacy personnel required to produce this hospital pharmacy service and their responsibilities will vary with the size, classification and organization of the hospital. A "Minimum Standard for Pharmacies in Hospitals"[6] and a recommended staffing pattern for "Pharmacy Personnel"[7] are available, and may be used as a guide in establishing the type of pharmaceutical service which will best serve the needs of the particular hospital for which it is designed. The hospital pharmacist with some formal training in hospital pharmacy administration plus additional experience in hospital pharmacy practice will be able to assess the requirements of the hospital in accordance with these established principles, and will be able to organize a pharmaceutical service which will be most suitable in terms of patient care and in keeping with the functions, organization and administration of the institution.

In this survey, hospitals in which the majority of beds are used for tuberculosis, mental, convalescent or other long-term illnesses, are classified as long-term hospitals. All other institutions were designated as short-term hospitals. The information has been compiled so that the pharmaceutical service in short-term hospitals may be compared with that in long-term hospitals, and also in hospitals owned and operated by the Federal Government such as the Department for National Defence, the Department of National Health and Welfare and the Department for Veterans' Affairs. Since 54.8%, or 92 hospitals of the 168 which responded to our questionnaire, employ only one pharmacist, statistical information is included on this group which represents hospitals of all types.

Staffing Pattern

The "Minimum Standard for Pharmacies in Hospitals",[6] section III, "Personnel" lists the following as "the ultimate in hospital pharmacy staffing" and includes:

1. Chief pharmacist
2. One or more assistant chief pharmacists
3. Staff pharmacists
4. Intern trainees (where intern program has been activated)
5. Non-professional trained pharmacy helpers
6. Clerical help.

The job classifications in the hospital pharmacy staff and the number of employees in each group will vary with the extent and scope of the operations carried on in the pharmacy department. The services provided by the pharmacy department, designed to meet the needs of the individual hospital, will determine the type and number of personnel and will vary with the size, classification and organization of the institution. Lyman and Sprowls[7] recommend the staffing pattern shown in Table III.

In the 50 to 99 bed group, 14 hospitals reported the employment of 12 full-time pharmacists and 4 non-professional staff. The total number of full-time pharmacists divided by the number of hospitals gives the figure of 0.86. The total number of non-professional workers divided by the number of hospitals gives the figure of 0.29.

If the workloads in the 168 Canadian hospitals approximate to those in the standard staffing pattern and are based on similar factors, the number of personnel in all bed groups is below the figure recommended.

In the literature, the number of pharmacists required by the average short-term hospital is frequently expressed in terms of the bed capacity of the hospital. "It is suggested that for the hospital to maintain utmost efficiency, the full-time services of a pharmacist are required in any hospital of 35 beds or over. For larger hospitals, there should be one pharmacist for every 100 beds."[9]

In this survey (see Table IV), 11

Table VI

M—Men W—Women	Bed Cap.	Alta.		B.C.		Man.		N.B.		Nfld.		N.S.		Ont.		P.E.I.		Que.		Sask.	
		M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Short Term Hospitals																					
Pharmacists		....	1	1	1	....	....	....	....	....	....	1	2	2	1	....	....	1	1	1	
Assist. Pharm.	50	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	
Pharm. part time	to	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	
Apprentices	99	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	
Non-professional		....	....	....	....	....	....	....	....	....	....	....	....	1	....	....	....	2	....	1	
Pharmacists		....	1	....	....	1	1	....	....	....	....	2	5	....	....	3	2	....	1		
Assist. Pharm.	100	....	....	....	....	....	....	....	....	....	....	....	1	....	....	....	....	....	....		
Pharm. part time	to	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....		
Apprentices	149	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....		
Non-professional		....	....	....	....	....	....	....	....	....	....	....	2	4	....	....	1	....	1		
Pharmacists		....	2	1	....	2	....	1	....	....	....	1	1	8	8	....	....	2	1	2	1
Assist. Pharm.	150	....	....	....	....	....	....	....	....	....	....	....	....	1	....	....	....	1	....	....	
Pharm. part time	to	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	
Apprentices	199	....	....	....	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	
Non-professional		....	1	....	1	....	1	....	....	....	....	2	1	10	....	....	....	2	1	1	
Pharmacists		2	2	....	....	2	2	....	1	....	....	....	2	2	....	....	....	2	....	....	
Assist. Pharm.	200	....	1	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....	
Pharm. part time	to	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	1	....	....	
Apprentices	399	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	
Non-professional		1	7	2	1	....	3	....	3	....	....	....	....	2	....	....	....	1	....	....	
Pharmacists		....	....	5	1	....	....	2	1	2	....	2	3	15	7	....	1	3	4	3	2
Assist. Pharm.	400	....	....	....	....	....	....	....	....	1	....	1	....	2	3	....	....	....	1	....	1
Pharm. part time	to	....	....	....	....	....	....	....	....	....	....	....	....	1	....	....	....	....	....	....	
Apprentices	499	....	....	....	1	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	
Non-professional		....	....	....	....	....	....	....	1	....	....	....	3	5	17	....	1	4	18	1	4
Pharmacists		3	1	3	....	....	2	....	....	....	....	....	....	12	29	....	....	5	19	6	4
Assist. Pharm.	500	2	....	....	....	....	....	....	....	....	....	....	....	1	6	....	....	2	6	....	....
Pharm. part time	to	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Apprentices	1,000	1	....	....	1	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional		....	1	....	2	....	3	....	....	....	....	....	1	8	20	....	....	13	19	2	2
Pharmacists		....	....	7	....	....	....	....	....	....	....	....	....	13	1	....	....	....	4	....	....
Assist. Pharm.	Over	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	1,000	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Apprentices		....	....	2	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional		....	....	2	2	....	....	....	....	....	....	....	....	7	3	....	....	....	....	....	....

	Alta.		B.C.		Man.		N.B.		N.S.		Ont.		Que.		Sask.		DVA		Nat. Def.		NHW	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Long Term Hospitals																						
Pharmacists	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Assist. Pharm.	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	1	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharmacists	....	1	....	....	....	....	....	....	....	....	1	....	....	....	....	....	1	....	1	....	....	....
Assist. Pharm.	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	1	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	....	....	....	....	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....	1
Pharmacists	....	1	....	....	1	....	....	....	....	....	....	....	1	1	....	....	2	....	....	....	2	....
Assist. Pharm.	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	1	....	....	....	....	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	1	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	2	....	....	....	....	....
Pharmacists	....	2	2	....	....	....	....	....	4	....	2	1	....	....	....	....	9	5	....	....	2	....
Assist. Pharm.	....	....	1	2	....	....	....	....	1	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	....	....	1	....	....	....	....	....	....	....	1	1	....	....	....	....	11	3	....	....	1	1
Pharmacists	1	....	2	....	....	....	....	....	....	....	....	....	1	2	1	13	....	....	....	....	1	....
Assist. Pharm.	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	1	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	....	....	2	1	....	....	....	....	....	....	....	....	....	....	1	....	27	3	....	....	....	....

	Totals		PFT		AP		PPT		A		N-P	
	M	W	M	W	M	W	M	W	M	W	M	W
Pharmacists	5	7	5	7	....	....	....	....	....	....	....	....
Assist. Pharm.	....	....	....	....	....	....	....	....	....	....	....	....
Pharm. part time	2	....	....	....	....	....	2	....	....	....	....	....
Apprentices	....	....	....	....	....	....	....	....	....	....	....	....
Non-professional	....	4	....	....	....	....	....	....	....	....	....	4
Pharmacists	11	10	11	10	....	....	....	....	....	....	....	....
Assist. Pharm.	....	1	....	....	....	1	....	....	....	....	....	....
Pharm. part time	....	1	....	....	....	....	....	1	....	....	....	....
Apprentices	1	..	....	....	....	....	....	....	1	....	....	....
Non-professional	6	5	....	....	....	....	....	....	....	....	6	5
Pharmacists	18	15	18	15	....	....	....	....	....	....	....	....
Assist. Pharm.	1	1	....	....	1	1	....	....	....	....	....	....
Pharm. part time	1	..	....	....	....	....	1	....	....	....	....	....
Apprentices	1	..	....	....	....	....	....	....	1	....	....	....
Non-professional	2	20	....	....	....	....	....	....	....	....	2	20
Pharmacists	12	12	12	12	....	....	....	....	....	....	....	....
Assist. Pharm.	..	2	....	....	....	2	....	....	....	....	....	....
Pharm. part time	3	..	....	....	....	....	3	....	....	....	....	....
Apprentices	..	..	....	....	....	....	....	....	....	....	....	....
Non-professional	6	18	....	....	....	....	....	....	....	....	6	18
Pharmacists	43	21	43	21	....	....	....	....	....	....	....	....
Assist. Pharm.	5	5	....	....	5	5	....	....	....	....	....	....
Pharm. part time	..	1	....	....	....	....	1	....	....	....	....	....
Apprentices	1	1	....	....	....	....	....	....	1	1	....	....
Non-professional	16	49	....	....	....	....	....	....	....	....	16	49
Pharmacists	44	67	44	67	....	....	....	....	....	....	....	....
Assist. Pharm.	6	15	....	....	6	15	....	....	....	....	....	....
Pharm. part time	..	..	....	....	....	....	....	....	....	....	....	....
Apprentices	1	2	....	....	....	....	....	....	1	2	....	....
Non-professional	36	54	....	....	....	....	....	....	....	....	36	54
Pharmacists	39	7	39	7	....	....	....	....	....	....	....	....
Assist. Pharm.	..	..	....	....	....	....	....	....	....	....	....	....
Pharm. part time	1	..	....	....	....	....	1	....	....	....	....	....
Apprentices	2	..	....	....	....	....	....	....	2	....	....	....
Non-professional	39	9	....	....	....	....	....	....	....	....	39	9
*Totals	172	139	12	24	7	2	6	3	105	159		
	311		36		9		9		246			

*The figures for Pharmacists include the Assistant Pharmacists.

Personnel Distribution in Canadian Hospitals Employing a Pharmacist

Table VII

Number of Pharmacists Per Hospital

	Part Time	1	2	3	4	5	6	7	8	9	Total
Alberta	4	7	3	..	1	1	..	..	..	..	16
British Columbia	2	7	2	3	2	..	..	1	..	..	17
Manitoba	..	6	2	..	1	..	..	..	..	..	9
New Brunswick	..	5	2	..	..	..	..	..	..	..	7
Newfoundland	..	..	1	..	..	..	..	..	..	..	1
Nova Scotia	..	7	4	..	1	..	..	..	..	..	12
Ontario	1	35	11	5	3	3	3	..	1	..	62
Prince Edward Island	..	1	..	..	..	..	..	..	..	..	1
Quebec	1	13	9	1	2	..	..	..	1	1	28
Saskatchewan	..	11	2	..	1	..	1	..	..	..	15
Yukon/North West Territories	..	..	..	..	..	..	..	..	..	..	..
	8	92	36	9	11	4	4	1	2	1	168
Percentage of hospitals to all hospitals reporting employment of pharmacists	4.8 %	54.8 %	21.4 %	5.3 %	6.5 %	2.4 %	2.4 %	0.6 %	1.2 %	0.6 %	100 %

Table VIII

Comparison of Standard Staffing Pattern (S) with 168 Canadian Hospitals Reporting (FS)

	50 to 99 beds (14)		100 to 149 beds (19)		150 to 199 beds (30)		200 to 399 beds (18)		400 to 499 beds (40)		500 to 1,000 beds (15)		Over 1,000 beds (15)	
	S	FS	S	FS	S	FS	S	FS	S	FS	S	FS	S	FS
Pharmacists														
Full-Time	1	0.86	1	1.11	1	1.10	2	1.33	5	1.60	6	3.47	7	3.07
Non-Professional	0	0.29	1	0.58	1	0.73	1	1.33	4	1.63	5	3.13	5	3.20
TOTAL	1	1.15	2	1.69	2	1.83	3	2.66	9	3.23	11	6.60	12	6.27

Table VIIIa

Number of Hospitals	Beds	Number of Pharmacists	Number of Non-professionals
14	50- 99	12	4
19	100- 149	21	11
30	150- 199	33	22
18	200- 399	24	24
40	400- 499	64	65
32	500-1,000	111	100
15	over-1,000	46	48

Table IX

120 Short-Term Hospitals
Number of Pharmacists per Number of Beds

50- 99	1	full-time pharmacist	for	every	.....	55.0 beds
100- 149	1	"	"	"	.....	87.4 "
150- 199	1	"	"	"	.....	130.0 "
200- 399	1	"	"	"	.....	146.6 "
400- 499	1	"	"	"	.....	247.3 "
500-1,000	1	"	"	"	.....	115.4 "
over-1,000	1	"	"	"	.....	142.0 "

short-term hospitals in the 50-59 bed group employ 10 full-time pharmacists. These 11 hospitals would have a total bed capacity of at least 550 beds or would employ one full-time pharmacist for every 55 beds. The number of pharmacists per number of beds reported by the 120 short-term Canadian hospitals is shown in Table IX.

If this staffing standard is accepted as being necessary for efficiency, Canadian hospitals of 150 beds and over do not employ a sufficient number of full-time pharmacists to enable these persons to utilize their professional training and ability to provide the best pharmaceutical service for patients and staff. As a result, duties which should be undertaken only by a pharmacist are entrusted to non-professional personnel and the chief pharmacist is unable to carry out his responsibilities in a manner which will give the hospital the best return on its investment in the pharmacy department.

Salaries

In the determination of the salary schedule for professional workers it is difficult to estimate the proper remuneration which should be assigned for the numerous intangible services which the enthusiastic and well qualified employee undertakes to improve the efficiency of his department for the benefit of the entire hospital. As an example, the setting up of a hospital formulary and the publication of monthly bulletins to inform the staff of recent developments in drug therapy might be included in this category. However, according to the Minimum standard:[6] "furnishing information concerning medication to physicians, interns and nurses . . . "co-operation in teaching courses to students in the school of nursing and in the medical intern training program" . . . and "implementing the decisions of the Pharmacy and Therapeutics Committee" are specifically mentioned as the responsibilities of the "pharmacist in charge". Monthly and annual reports, which serve as a yardstick of pharmacy service and progress, should contain information on professional activities as well as statistics on the number of prescriptions and ward requisitions filled, the number of items manufactured and the amount of inventory. Since the reporting system varies in each hospital, it is difficult to make true comparisons of salaries and workloads although the hospital bed capacity, out-patient activity and hours of work may be fairly uniform. In addition, in some hospitals, the pharmacist may serve as the purchasing agent for the entire hospital or be engaged as the assistant administrator and these factors should be taken into con-

Table X

Salaries, Workloads, Hours, Benefits, Other Duties.	Part I Short Term Hospitals: 50 to 99 beds (11)	99 to 149 beds (14)	150 to 199 beds (26)	200 to 399 beds (11)	400 to 499 beds (34)	500 to 1,000 beds (21)	Over 1,000 beds (3)	Part II: Veterans (14)	National Defence (4)	National Health & Welfare (8)	Long-Term (22)	All Types Employing ONE Pharmacist (92)
SALARIES												
MEN												
$7,000 - $7,999	..	..	2	..	..	..	1	..	..	..	..	1
$6,000 - $6,999	..	..	..	..	2	1	1	..	..	..	..	..
$5,000 - $5,999	1	..	1	1	5	6	3	..	3	..	..	4
$4,000 - $4,999	..	2	5	4	12	15	13	10	2	3	3	17
$3,000 - $3,999	1	4	8	1	8	7	2	18	..	4	10	26
$2,000 - $2,999	..	..	1	..	3	..	..	..	..	..	..	1
Below $2,000	1 pt.	..	..	1 pt.	..	..	..	1 pt.	..	1 pt.	2	..
Not Given	1	..	..	..	4	..	..	2	..	..	2	3
WOMEN												
$6,000 - $6,999	..	..	..	..	..	..	..	..	..	..	1	1
$5,000 - $5,999	..	..	..	..	1	1	..	..	..	..	..	..
$4,000 - $4,999	1	1	2	2	6	18	1	..	..	1	2	7
$3,000 - $3,999	..	8	9	3	4	31	..	5	..	..	4	15
$2,000 - $2,999	2	2	1	1	4	2	..	..	..	..	..	6
Below $2,000	..	..	..	..	1	..	..	..	..	..	2	..
Sisters	3	..	1	3	4	10	..	..	..	..	3	10
Not Given	1	..	..	..	1	..	..	..	..	..	..	1
Other Benefits												
Room	1	2	1	..	4	17	..	..	..	..	1	7
Uniforms	4	5	6	2	21	40	6	13	1	5	15	37
Laundry (uniforms)	1	6	12	1	17	35	1	11	..	2	7	33
1 or more meals a day	2	4	2	..	9	28	..	5	..	3	..	11
Blue Cross	1	1	1	1	6	19	6	5	..	..	3	6
Average No. of hours per pharm. per week	52	42	46	46	47	45	41	42	43	40	45	46
Average No. of hours pharm. open per week	52	54	55	62	57	60	55	44	43	42	53	54
Average Work Load per Pharm.	..	..	..	..	..	..	..	..	..	..	..	..
Average No. of prescriptions per hour	1.8	3.7	10.0	9.1	11.7	9.3	9.0	5.3	3.8	1.1	6.4	7.9
Average No. of ward orders per hour	1.5	4.9	4.7	18.2	10.6	10.8	1.7	6.7	0.7	6.9	6.5	7.9
TOTAL	3.3	8.6	14.7	27.3	22.3	20.1	10.7	12.0	4.5	8.0	12.9	15.8
Other Duties												
Purchasing Agent for the Pharmacy	10	13	24	9	28	17	2	4	4	6	11	71
Purchasing Agent for the Hospital	5	1	6	..	3	..	..	..	2	..	..	9
Lectures to Nurses and Medical Students	1	2	11	3	16	10	1	2	..	1	4	25
Clerical or secretarial work	..	..	..	..	2	..	..	..	..	..	1	2
On call nights, holidays, Sundays	9	6	21	8	27	16	2	11	..	4	11	58
Hospital Administrator	..	..	1	..	..	..	..	..	..	..	..	1
Assistant Administrator	1	..	..	..	..	..	..	..	1	..	..	1
Average No. of prescriptions per hosp. per month	416	793	2,154	2,429	3,565	6,749	11,399	3,110	887	193	1,353	1,586
Average No. of ward orders per hosp. per month	339	1,013	1,328	4,175	3,326	4,656	2,186	3,937	167	1,198	1,403	1,591
TOTAL	755	1,806	3,482	6,604	6,891	11,405	13,585	7,047	1,054	1,391	2,756	3,177

sideration in a comprehensive salary survey along with other variables such as room, meals, laundry, Blue Cross and other benefits which are included in some salary schedules.

The "Minimum Standard for Pharmacies in Hospitals" has been adopted by the Canadian Society of Hospital Pharmacists in principle, and the members are endeavouring to establish the practice of hospital pharmacy in our Canadian hospitals on this basis. In accordance with the first point in the Standard of Organization which states "There shall be a properly organized pharmacy department under the direction of a professionally competent, legally qualified pharmacist whose training in hospital pharmacy conforms to the standards herein established by the Division of Hospital Pharmacy sponsored by the American Pharmaceutical Association and the American Society of Hospital Pharmacists".[6] Many Canadian pharmacists hold membership in the American Pharmaceutical Association and the American Society of Hospital Pharmacists, and attend annual institutes and refresher courses on the professional practice of hospital pharmacy in order to expand and increase the service of the pharmacy department and make it more valuable to the hospital. Courses in hospital pharmacy administration are now taught in our colleges of pharmacy and, with this training plus a few years of experience as an assistant hospital pharmacist, these members are taking their place in the profession as efficient and enthusiastic hospital pharmacy administrators. The possession of a pharmacy degree and license does not entitle a hospital pharmacist to any fixed salary. Selection of personnel and remuneration should be made on the basis of training and/or experience in hospital pharmacy practice, ability to institute sound department management in keeping with hospital policies, ability to co-operate with the medical staff and serve as drug therapy consultants, and ability to give instruction to pharmacy department personnel and also to interns and nurses—either on a formal or informal basis.

Table XI

Average Salaries in Short-term Hospitals

	Men		Women	
	Annual	Weekly	Annual	Weekly
50- 99	$4,500	$86.53	$3,166	$60.88
100- 149	3,833	73.71	3,409	65.55
150- 199	4,323	83.13	3,583	68.90
200- 399	4,500	86.53	3,666	70.50
400- 499	4,333	83.32	3,625	69.71
500-1,000	4,534	87.19	3,846	73.96
Over-1,000	4,800	92.30	4,500	86.53
Average—ALL	4,403	84.67	3,685	70.86

Table XII

Comparison of Short and Long-Term Hospitals with Federal Government Hospitals

	Hours, Workloads, Salaries				
	Short-term	Long-term	National Defence	National Health & Welfare	Veterans
	(120)	(22)	(4)	(8)	(14)
Hours Pharmacist on duty per week	45.5	45.0	43.0	40.0	42.0
Hours Pharmacy open per week	54.6	53.0	43.0	42.0	44.0
Work Load	15.3	12.9	4.5	8.0	12.0
Average Salary Men	$4,403	$3,500	$5,100	$3,928	$3,857
Average Salary Women	$3,685	$3,722		$3,500	$3,500

Information on salaries, benefits, workloads and other duties of hospital pharmacists in Canadian short-term public general hospitals from 50 to 1,000 beds is tabulated in Table X.

The average salaries on an annual and weekly basis for men and women in short-term hospitals is indicated in Table XI.

In the 50 to 99 bed group, one full-time male pharmacist is reported to have a salary of between $5,000 and $5,999 (taken as $5,500) and another between $3,000 and $3,999 (taken as $3,500). The total, $5,500 plus $3,500, or $9,000 divided by two gave an average for this group of $4,500 a year.

The salaries for women are considerably lower than those reported for men in all bed groups and appear to increase with the size of the hospital. However, the principle of equal pay for equal work does not seem to apply—for some hospitals reported their pharmacy departments completely staffed by women pharmacists. Salaries for men in the small hospitals,

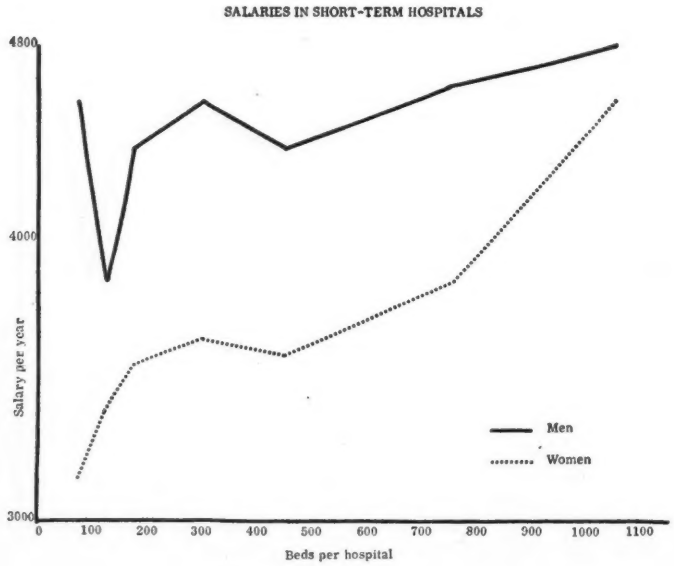


Fig. 1

50-99 beds, are considerably higher and in these hospitals five pharmacists serve as the purchasing agent for the hospital and one is reported as the assistant administrator.

The average number of hours that the pharmacy is open per week varies from 52 hours to 62 hours, with the longest hours of service indicated in the 200 to 399 bed group. The average number of hours that the pharmacist is on duty per week varies from 41 hours to 52 hours, and the numbers of hours decrease with the size of the hospital.

The total workload varies from 3.3 to 27.3 prescriptions and ward orders per hour, with the peak reported in hospitals of from 200 to 399 beds.

If salaries were based on the workload per hour, then the pharmacists in these hospitals should receive a much larger annual income. In 3 of these 11 hospitals the pharmacists give lectures to nurses and medical students, but no pharmacist does purchasing for the entire hospital.

Although workloads and salaries are relatively better proportioned in the 400 to 499 and 500 to 1,000 bed groups, the staffing pattern in these hospitals is much lower than the recommended standard. In order to spread the workload more evenly more staff is indicated in these groups, or—if salaries are based on proportional workloads—a higher annual income should be received by pharmacists in these hospitals. It is most commendable that the pharmacy staffs in the 34 hospitals in the 400 to 499 bed group, with a workload of 22.3 prescriptions and ward orders per hour, still find time to do purchasing for the entire hospital in 3 institutions and in 16 hospitals to give lectures to nurses and medical students.

Information on hours, workloads and salaries in all short-term hospitals may be compared with similar statistics for long-term hospitals and those owned and operated by the departments of the Federal Government in Table XII.

In hospitals owned and operated by the Department of National Defence, the salaries reported were proportionally higher on the basis of workloads and hours of service, than those in other Federal Government hospitals. The average workload and hours of service in the Veterans' hospitals are less than in the long and short-term hospitals, and the average salary of male pharmacists is higher than that received by male pharmacists in long-term hospitals, but lower than that received by male pharmacists in the short-term hospitals. Average salaries paid to male pharmacists in Veterans' hospitals are lower than the average of all other Federal Government hospitals.

HOURS IN SHORT-TERM HOSPITALS

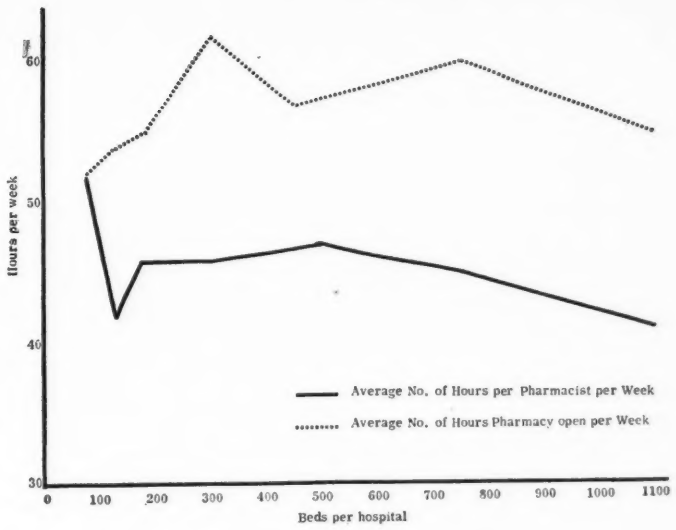


Fig. 2

WORK LOADS IN SHORT-TERM HOSPITALS

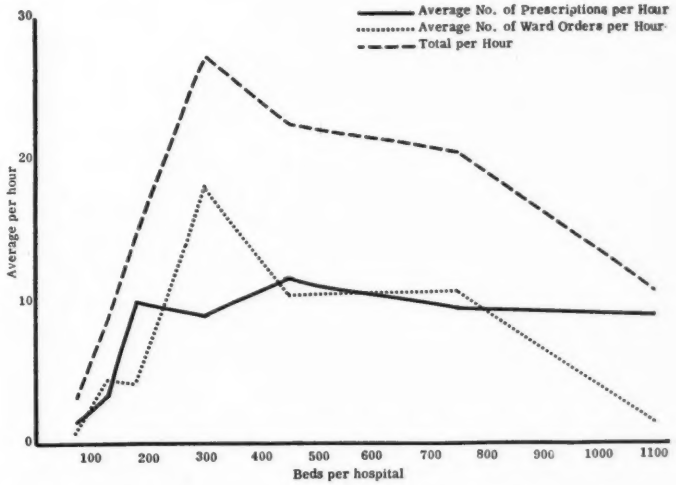


Fig. 3

In the long-term hospitals, the average salary paid to women exceeds the average salary paid to men.

Information on salaries, benefits, workloads and other duties of hospital pharmacists in Canadian long-term hospitals and Federal Government hospitals is tabulated in Part II of Table X. Information on all types of hospitals which employ only one pharmacist is also included in Part II of Table X.

(Concluded in September Issue)

Bibliography

1. Joint Commission on Accreditation of Hospitals: In, *Standards for Hospital Accreditation,* Chicago, Ill.

2. Canadian Hospital Association, *Canadian Hospital Directory,* Toronto, 1955, p. 40.

3. American College of Hospital Administrators: "Continue Group Report on Directive Problems—Care of Prolonged Illness, *ACHA News,* Vol. 19, p. 3, May 1956.

4. Cook, E. F. and Martin, E. W., *Remington's Practice of Pharmacy,* The Mack Publishing Company, Easton, Pennsylvania, 1951, p. 1337

5. Ferguson, R. B., "Small Hospitals —Don't overlook the pharmacist's contribution", *Canadian Hospital,* 32:44, 1955

6. Cook, E. F. and Martin, E. W., *op.cit.,* p. 1336

7. Lyman, R. A. and Sprowls, J. B., *Textbook of Pharmaceutical Compounding and Dispensing,* J. B. Lippincott Company, Philadelphia, 1955, p. 417.

8. Cook, E. F. and Martin, E. W., *op.cit.,* p. 1343

Vancouver Welcomes

Western Canada Institute

Jessie Fraser

THE sun shone fair on Vancouver during the eleventh Western Canada Institute for Hospital Administrators and Trustees, held June 11th to 15th. The lawns and boulevards of the University of British Columbia were lush green under foot as some 600 persons in attendance hastened from building to building during the day or strolled in the fresh evening air. To those who came from distant places, sunset over Burrard Inlet, with the mountains all gold and amethyst, was a source of special delight.

Those registered came from all areas of the Canadian west, together with visitors from farther east and from the United States. Taking the full 5-day course were 206 registrants: from British Columbia, 116; Alberta, 39; 41 from Saskatchewan; and 10 from Manitoba. Some 150 were able to stay for only part of the course, and there were many local visitors attending particular sessions. Delegates to the meeting of the Auxiliaries' Division of the British Columbia Hospitals' Association, meeting separately for two days (see p. 70), helped increase the total.

A second concurrent event was the Nursing Administration Work Conference on Monday, June 11th, and Tuesday, June 12th (see p. 52).

General sessions were held in the university auditorium; and the armouries across the street accommodated the exhibits of some 45 hospital supply houses. Among other booths was a comfortable area labelled, "British Columbia Hospital Insurance Service", where registrants were invited to sit and rest. The program provided a 30-minute period each morning and afternoon for visiting the exhibits and, through excellent chairmanship, the sessions were so timed as to allow for inspection of the exhibits.

A notable feature of the institute was the amount of time allotted to panel discussions. In the general plan of the program one to three brief addresses were presented each morning or afternoon, followed immediately by a panel, a round table, or plenty of time for questions and answers. Besides the speakers on specific subjects a "faculty-at-large" assisted at these discussion sessions. The members of this faculty were: Dr. A. C. McGugan, superintendent, University of Alberta Hospital, Edmonton; Dr. W. Douglas Piercey, executive director, Canadian Hospital Association, Toronto; Dr. A. L. Swanson, executive director, University Hospital, Saskatoon, Sask.; Dr. Edwin L. Crosby, director, American Hospital Association, Chicago, Ill.; Dr. A. J. Brunet, medical superintendent, St. Joseph's Hospital, Victoria, B.C.; and Donald M. Cox, Hospital Insurance Commissioner for British Columbia.

B.C.H.I.S.

In an address following formal opening ceremonies, the Hon. Eric Martin, Minister of Health and Welfare, Province of British Columbia, referred to the days before B.C. had government-sponsored hospital insurance as a time when "nothing escaped the inflationary spiral of costs and the hospitals felt the increasing pinch very severely". Hospitals then needed immediate cash assistance if they were to keep their doors open, he said, and the provincial government had no alternative but to give "millions upon millions of dollars to ensure operation of these vital facilities". Something had to be done, and the answer was a prepaid hospital insurance plan "to give the people the protection they wanted."

The speaker then sketched developments in the field of hospital affairs in British Columbia during the past eight years, *i.e.*, since the introduction of hospital insurance. In the first few years there were many misunderstandings on the part of the public, he said. One was because hospitals had been charging one rate for board, room, and nursing service, with fees for other services, whereas under hospital insurance all were amalgamated to form one daily rate — which appeared more costly at a superficial glance. Again, the system of premium collection was based upon compulsion, and this many people resented.

For these and other reasons, the financing of the whole plan was changed; the premium levy was dropped, and the sales tax increased from 3 per cent to 5 per cent. This tax pays for not only hospital insurance but for all social services in the province, including an extensive welfare program. Under this system, Mr. Martin said, "the plan is operating to the complete satisfaction of the public".

On the other hand, Mr. Martin admitted, "keeping hospital costs within the ability of the paying public is certainly not an easy task", and he expressed appreciation for the co-operation received from trustees and administrators in the province. The hospital insurance service is now paying to the hospitals some $80,000 a day — day in and day out, he said. It was noted also that "hospital construction can almost be described as a basic industry in British Columbia now, and that the province grants 50 per cent of all con-

Hon. Eric Martin, Minister of Health and Welfare, province of British Columbia, and Mrs. Martin discuss the program with Donald M. Cox, Commissioner of the B.C.H.I.S.

Happy greetings in the auditorium. Left to right: L. F. C. Kirby, New Westminster; Dr. A. L. Swanson, Saskatoon; L. R. Adshead, Edmonton; Glyn Myers, Regina; and Percy Ward, Vancouver.

Seen here, left to right, are: A. K. McTaggart, Brandon, Man.; Sr. Alice Gauthier, Edmonton; Sr. Gertrude Jarbeau, St. Boniface, Man.; and Robert G. Goodman, Winnipeg.

Viewing an exhibit here are, left to right: A. H. Rose and Mr. Blewett of the B.C.H.I.S.; Mrs. G. C. Chandler, Vancouver; A. S. Lightfoot, Campbell River, B.C.; and Walter M. Zet, Invermere, B.C.

Checking the program between sessions. Left to right: Sr. Gerard du Rosaire, Castor, Alta.; Sr. Rosalie Marie, Pincher Creek, Alta.; Mother Beatrice, Castor; and Sr. M. Roderick, Pincher Creek.

Mrs. A. J. Tripp and Mrs. C. S. Stigings, both of Vancouver, examine a sketch of Holy Family Hospital in that city. It is the work of architects Whittaker and Wagg, Victoria.

struction costs. In addition, the British Columbia Hospital Insurance Service engages many technical experts who provide free consultative services in matters pertaining to hospital planning.

In conclusion, Mr. Martin stressed the impact of the B.C.H.I.S. upon national thinking with respect to a country-wide program. He said that in 1953 and 1954, when informal discussions were held between representatives of the Department of National Health and Welfare and hospital representatives from all provinces, apprehension was expressed that rapidly-rising hospital costs in British Columbia would prove discouraging to other provinces and delay the development of a Canada-wide program indefinitely. However, he pointed out that since the development of the firm-budget policy in British Columbia, and with the assistance of hospital authorities, the actual rise in costs has been more reasonable. This fact is of interest to all provinces, said the Minister, "since it proves that, with intelligent control and co-operation, costs can be held within the ability of the public to pay for the services provided".

Employer-Employee Relationships

A whole session, under the chairmanship of Harvey Taylor of Port Alberni, was devoted to this general subject. Speakers were T. R. Watt of Management Research Limited, Vancouver, and W. M. Black, Business Manager, Local 180, Hospital Employees' Federal Union.

Speaking from the point of view of management, Mr. Watt emphasized that lines of communication between employers and employees must be kept open at all times. Trade unions, he reminded his listeners, came into being through lack of such communication and are needed to represent the voice of large employee groups. In very small hospitals, he said, every employee is probably known to the administrator by his first name but, in large institutions, this is obviously impossible and hence the administrator must talk with employee representatives. More and more hospital workers have found it necessary to organize formally in order to have their views placed before those in managerial posts. One of the staffing difficulties encountered by hospitals is caused, he said, by the fact that, while the union wage structure is minimal, hospital authorities consider it maximal. They do this, Mr. Watt pointed out, because it is necessary to achieve efficiency at as little cost as possible, but it does result in increased staff turn-over, which may well defeat the purpose.

W. M. Black, presenting the employees' point of view, spoke of the importance of "a healthy, resourceful, well-trained working force and, what is of utmost importance, employee morale." Low morale, he said, is as a rule the result of poor organization and poor employer-employee relationships. Hospital administrators, according to Mr. Black, should expect and receive a fair day's work for a fair day's pay. They should welcome suggestions made by employees at any time; in fact, the operation of a hospital should be a co-operative venture — "good teamwork, all pulling together". He insisted that employees are entitled to proper working conditions, reasonable perquisites, and wages equal to those paid in other public services. You cannot, Mr. Black said, peg or restrict the standard of living of one group of employees in the community. Speaking of trade unions, he begged administrators not merely to tolerate but to accept them — because unions have been responsible for many social reforms and the "union movement is a respected part of the Canadian way of life."

With T. R. Watt as moderator, a panel discussion on this subject was then held. Members of the panel were: Harvey Taylor of Port Alberni, H. P. J. Gunn, Vancouver; Sister Mary Ruth, Vancouver; and W. J. Cook, Burnaby. In the lively discussion which followed, in-service training and the value of regular staff meetings were stressed again and again. Well-trained supervisors were deemed of utmost importance. The question of whether or not annual increments should be part of the wage structure brought forth various opinions. In general, ways and means of stabilizing hospital staff were reviewed, with reference chiefly to non-professional workers.

Hospital Administration

The director of Royal Columbian Hospital in New Westminster, L. F. C. Kirby, presented an authoritative address outlining the basic principles of administration. He described management as an art, "one not likely ever to become an exact science but increasingly based upon science". An aspect common to all hospitals large and small, he said, is that each constitutes an association of persons drawn together from all walks of life, whose common purpose is improved practices for the welfare of the patient and a better hospital tomorrow.

The activities involved in administration, Mr. Kirby pointed out, could be analyzed as six basic processes: definition of objectives, planning and techniques, personnel relationships, organization and co-ordination, control and appraisal, and direction and communication. He stressed the importance of delegating authority adding that "authority and responsibility must be co-terminous, co-equal, and well defined". Constant attention must be given, Mr. Kirby said, to the development of leadership skills, remembering that approximately 40 per cent of management is specific "know how" and 60 per cent is ability to work with others. Co-operation, he added, is not a one-way street.

With Mr. Kirby as moderator, the faculty-at-large acted as a panel to answer questions submitted in writing or asked from the floor. Subjects discussed ranged from whether a sick child's clothes should be sent home to the difficulty of organizing medical staff in very small hospitals, and who is responsible for keeping trustees informed. The work of standing committees received attention, and it was pointed out that in very small hospitals it might be possible to have only one —a "committee of the whole".

Public Relations

"What the Community Expects of Its Hospital" was the subject of an

address by Frank Wilson, director of public relations, Annacis Industrial Estates, New Westminster. Mr. Wilson presented what he believed to be the viewpoints of the family, the wage-earner, the businessman, and community groups who plan hospitals.

He pointed out that the head of every household looks upon the hospital as a haven in time of illness, a place where he will find reassurance and understanding. The wage-earner, relieved of fear of debt through illness, expects the service to which he feels himself entitled. Businessmen have a growing concern for the health of employees, and many industries take into consideration the hospital facilities available when establishing new plants. Hospital planners may be administrators or special groups in the community who feel it reasonable to have adequate hospital accommodation available at all times.

Mr. Wilson pointed out that all these types expect the hospital to provide sympathetic care of the patient, the finest equipment in all departments, recognition of the spiritual needs of the patient, businesslike administration, and a highly competent staff. The speaker added that both administrators and trustees should take every opportunity to make clear to the community what present-day problems are and what sound planning for the future can bring.

With L. F. C. Kirby as moderator, the faculty-at-large again discussed questions submitted. The value of good press relations was stressed and regular press conferences were suggested as a means of achieving accuracy in the news. A trustee who was also an editor urged that the press can help to counteract damaging rumours.

Medical Records and Accreditation

This subject was introduced by Dr. J. A. Brunet, medical superintendent of St. Joseph's Hospital in Victoria, who used slides to illustrate his talk. Formerly a field surveyor for the Joint Commission on Accreditation of Hospitals, Dr. Brunet pointed out ways and means by which hospitals may achieve good records — as one step toward accreditation. He urged that the necessary facilities must be provided before doctors can be expected to complete forms. Then there must be adequate indexes so that records are available immediately for future use, *i.e.*, for re-admission, for legal defence, or educational purposes.

In very small hospitals, he suggested that a clerk in the front office could index the few admissions by name, disease, and operation. To place the number of the patient on all other cards is simple and effective, he said — adding quickly that no system is of use unless the record is written. The staff must be persuaded not only to complete records but to use them. To meet once a week and review cases is self-education for physicians, and is also adequate for purposes of accreditation, he said.

J. W. Carnwath of Fernie, B.C. confers with Sr. Florina and Sr. Margaret Marie, Vancouver

As in other sessions, a panel then took over the subject. Those on stage were Dr. Brunet as moderator; Dr. W. J. Cochrane, chairman, Medical Records Committee, St. Joseph's Hospital Victoria; Sister M. Catherine, R.R.L., of the same hospital; Lillian McNee, R.R.L., Shaughnessy Hospital, Vancouver; Mrs. Ruth Melby, R.R.L., Royal Columbian Hospital, New Westminster; and Dr. Edwin L. Crosby, director, American Hospital Association.

There were many questions concerning the problem of the doctor who refuses to complete his records, and how to persuade him to conform. It was emphasized that each physician owes it to his patient to keep a record because, in the words of Dr. Crosby, "one line of faded ink is worth a thousand memories". It was pointed out that in some small places physicians tended to keep records in their offices rather than at the hospital; and Dr. Brunet suggested that they be given blanks with carbons and encouraged to send at least copies to the hospital. To withdraw a physician's hospital privileges for non-completion of records should be a last resort, it was generally agreed.

Study of Comparable Hospitals

During the weeks prior to the Institute, representatives of four comparable hospitals studied the details of operation in their own institutions and to some extent those of the other hospitals concerned, and came prepared to report their findings and discuss them. The members of this panel were Sister Mary Geralda, medical record librarian, St. Mary's Hospital, Camrose; G. W. Myers, executive director, Saskatchewan Hospital Insurance Service, Regina (who made a study of Swift Current General Hospital, Swift Current, Sask.); A. K. McTaggart, administrator, Brandon General Hospital, Brandon, Man.; and J. E. Bragg, ad-

Gordon Frith of Nanaimo and Mrs. Edith Pringle, Vancouver, examine one of the displays.

J. A. Abrahamson of Revelstoke, President of the B.C.H.A., presides at opening ceremonies. Sitting, left to right: Dr. Palmer McLean, Vancouver; H. R. Slade, Powell River; and the Minister of Health and Welfare, Hon. Eric Martin

ministrator, North Vancouver General Hospital, Vancouver.

According to rated capacities, the hospital in Brandon is somewhat larger than the others, having 151 beds. Swift Current is listed as having a total of 128; while that at Camrose has 120; and North Vancouver, 124. Of these, only Brandon has a school of nursing. Many striking differences between the hospitals were revealed and these were partly due to their location — two being situated in large cities, while the others draw patients from rural areas as well as from their own centres. Again, in Vancouver the 40-hour work week prevails — which results in a higher number of personnel and somewhat higher costs than in the other provinces. The Brandon General has a very old plant (an entirely new one is being planned) and hence personnel there may well suffer certain handicaps not experienced in the newer hospitals. Another factor which has some bearing on the operation of the individual hospitals is government sponsored hospital insurance. Such a system does prevail in British Columbia, in Saskatchewan, and partially in Alberta. While a large percentage of the population in Manitoba is covered by some form of insurance, including Blue Cross, that province has no government-sponsored scheme.

The four presentations were succeeded by rapid-fire discussion both from the floor and among panel members. While interesting contrasts between the hospitals concerned came to light, the session may well be summed up in the words of G. W. Myers, who said: "The point which has impressed me most strongly in this review of four hospitals in Manitoba, Saskatchewan, Alberta, and British Columbia is the similarity of the main operating features. There are some differences, of course, but in practically every case these are the result of readily identifiable factors. It seems evident, in other words, that in any province the setting up of general hospital facilities of a given size is likely to result in a predictable pattern of operations."

Control of Infections in General Hospitals

The session devoted to this subject, under the chairmanship of Sr. Mary Ruth, St. Vincent's Hospital, opened with an address by Dr. A. C. McGugan, Edmonton, under the heading "Epidemiology in General Hospitals." This took the form of an elementary discussion designed for the guidance of lay administrators and nursing staffs. The speaker recommended certain procedures designed to safeguard the patient and his environment, explained the rationale for those procedures, and advised administrators to seek the assistance of a competent epidemiologist if an infection should become endemic in the hospital.

Dr. McGugan warned that "to the public any communicable disease case or infection developing during the period of a patient's hospitalization is the result of a cross-infection and evidence of negligence on the part of the hospital staff — and the courts appear to be quite sympathetic to the public's point of view in this case". He pointed out that sometimes cases of diseases at a communicable stage are admitted to general hospitals unwittingly. He suggested that the number of such cases might be reduced by taking a careful pre-admission history, which would reveal any possible exposure, and a careful pre-admission examination, either in the patient's home or in the admitting unit.

As well as giving concise but specific recommendations concerning the management of communicable diseases in general hospitals, the speaker made available in tabulated form a digest of certain pertinent information regarding common communicable diseases and also certain information regarding the prevention and treatment of communicable diseases by chemotherapeutics and antibiotics.

With Dr. McGugan as moderator, a panel discussion followed in which a great many of the questions asked had to do with the control of staphylococcal infections in hospitals. Included in the panel were: Dr. J. C. Colbeck, Shaughnessy Hospital, Vancouver; Dr. W. H. Sutherland, a Vancouver surgeon; Dr. A. Larson, Consultant in Epidemiology to the B.C. Department of Health and Welfare; and Dr. A. L. Swanson, executive director, University Hospital, Saskatoon.

Dr. Colbeck outlined the original investigation which he and his associates at Shaughnessy Hospital have done in connection with staphylococcus aureus. With the introduction of the antibiotic drugs, he said, it soon became apparent that many strains of staphylococcus aureus became resitant to penicillin and other of the new drugs. The speaker contended that more attention must be paid to the ordinary antiseptic principles as enunciated in Lister's day. He presented slides which portrayed how infection can readily spread from bandaged wounds to bed linen and matresses. The problem of how to disinfect a spring mattress properly had given him and his associates much concern, Dr. Colbeck said, and it was their opinion that the average hospital was not giving this matter the attention it merited. He pointed out that there are many strains of staphylococcus aureus but that in most cases of infection among hospital workers and patients Type 81 was the offender. The incidence of staphylococcal infections are said to be much higher among hospital workers than in the general population.

Mental Illness and General Hospitals

Dr. A. L. Swanson, administrator, University Hospital, Saskatoon, pointed out that for far too long there has been a tendency to isolate cases of mental illness in institutions unconnected with general treatment centres. The realization that many cases should be treated in general hospitals is comparatively new in Canada, he said, though many hospitals have established psychiatric units in recent years.

He outlined the conclusions arrived at by the National Scientific Planning Committee, which was appoint-

(Concluded on page 66)

Also at the Institute . . .

Examining with interest an over-bed table. Left to right here: Mrs. F. E. Atkinson, Summerland, B.C.; Mrs. Forbes Perkins, Vancouver; Mrs. H. Bernardo and Mrs. I Caruso of Michel, B.C.; and Mrs. G. Butler, Summerland.

In this group, all from B.C., are: Sr. Francoise Therese, Cranbrook; Sr. Laura Marie, Dawson Creek; Sr. John of the Passion, Cranbrook; Sr. Mary Dennis, Vancouver; and Sr. Rollande Bernadette,, Vanderhoof.

Six B.C. delegates caught by the camera in this one. Left to right: Arthur Rutherford, and Mrs. J. L. Kelly, both of Prince Rupert; W. E. Dipple, Ganges; Robert G. Moore, Prince Rupert; Miss E. Clark, Powell River; and Klaus Scheer, Grand Forks.

E. W. Holborne of the B.C.-H.I.S. chats with Sr. M. Jeanette, Sr. M. Louise, and Sr. M. Laurene, all of Comox, B.C.

(Photos by Jack Cash, North Vancouver)

In Conjunction with the Western Canada Institute

Work Conference on Nursing Service Administration

Margaret M. Street,
Associate Director of Nursing Service,
Calgary General Hospital,
Calgary, Alta.

INCLUDED in the program of the eleventh Western Canada Institute for Hospital Administrators and Trustees was a work conference on Nursing Service Administration, the theme of which was, "Current Problems in Meeting the Nursing Needs of the Patient in Hospital". The work conference, planned by a Joint Committee of the University of British Columbia School of Nursing and the Registered Nurses' Association of British Columbia, was held on June 11 and 12, 1956, at the University of British Columbia School of Nursing. Evelyn Mallory, Professor of Nursing, University of British Columbia, welcomed the 99 participants, who were engaged in the following fields of nursing service:

Administrators	2
Directors of Nursing	39
Assistant Directors of Nursing	8
Supervisors	21
Head Nurses	13
Assistant Head Nurses	1
Staff Nurses	2
Instructors	11
Hospital Inspectors	1
R.N.A.B.C. Office	1

Session I was concerned with identification of current nursing service problems; Session II reviewed principles and methods in preparation of the nursing service budget, with particular reference to staffing requirements to provide for the nursing needs of patients in hospital; and Session III discussed ways and means of utilizing most effectively the resources available to the department of nursing in order to give optimum care to patients. The Problems Clinic, an open session, held on the evening of June 11, and chaired by Edna Rossiter, Director of Nursing, Shaughnessy Hospital, dealt with miscellaneous problems of nursing service administration raised by individual participants and groups. The full report of the Problems Clinic is contained in the proceedings of the Western Canada Institute.

Session I

In an introductory lecture, the conference director referred to the multiplicity of complex factors which affect the concept, the quantity and the quality of the present-day hospital nursing service. These include: the needs of individual patients; changes in medical and in nursing practice; social influences; current health problems and programs; trends in hospitalization and the demand for and utilization of hospital services; the economy of the country; education and research in nursing and allied health professions; the availability of nursing personnel (professional and non-professional) and the availability of services, for total patient care, of other health workers, other hospital departments, and community organizations and resources.

For the purpose of discussing major current nursing service problems, participants were divided into groups representing hospitals of various sizes, 1-49 beds; 50-99 beds; 100-299 beds; and 300 beds and over. When the groups reported, at the end of the first session, it was noted, with considerable surprise and interest, that a great many of the current problems are common to larger and smaller hospitals alike.

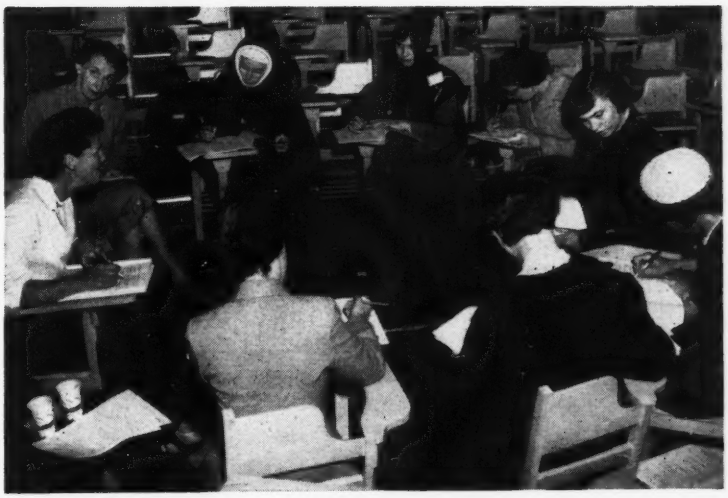
Major nursing service problems were identified under four headings.

A. Determination of staffing

Expert guidance is needed for individual hospitals and their departments of nursing regarding research methods which may be used in analyzing the quantitative and qualitative nursing needs of patients. It will then be possible to determine desirable standards of nursing care in various clinical services, age groups, and degrees of dependency (physical and emotional) and ratios of professional to non-professional nursing personnel.

The department of nursing must

continually evaluate the quality of care being given in each clinical area of the hospital, under established standards, and the development of criteria and techniques to assist such evaluation. Revision of such existing standards of nursing care as indicated must be carried out upon recommendation of the director of nursing, through appropriate action by administrative officers of the hospital. The student nurse contribution to the nursing service of the hospital may also be examined as a basis for budget computations, taking into consideration the responsibility of the hospital to safeguard the patient care and the needs of students as learners. This involves a study of the effectiveness, in terms of graduate nurse service, of service given by students at various levels in the curriculum. Finally, it was felt that when budgetary policies are being established, directors of nursing should be brought into consultation; the development of the department of nursing budget, for submission to the hospital administrator, should be a co-operative activity, involving the director of nursing, her associates, supervisors and head nurses. The need for research into the kinds and amount of nursing care needed by long-term and geriatric patients was also recognized.



One of the study groups

B. Availability of Nursing Personnel

The shortage of qualified nursing personnel, professional and non-professional, is felt most keenly in the smaller hospitals in isolated areas. Staff shortages are most noticeable during the holiday seasons and at other peak periods. Turnover of staff remains a serious problem to the nursing service administrator. The continuous heavy service load — the increase in admissions, shortened hospital stay, overcrowding of wards — all contribute to the problem of providing good nursing care and maintaining high morale among nursing personnel.

The absence of centralized courses and certification of orderlies obliges hospital departments of nursing to establish job-in-training programs for these workers. Such programs are not uniform, and they do not confer recognized status. Schools of nursing are not able, in the present basic program, to prepare nurses to assume, immediately upon graduation, all the responsibilities which may be required of them in the smaller hospital. Many nurses who have always lived in larger centres and who have trained in large schools appear to be reluctant to take positions in smaller communities.

C. Personnel Policies

There is need for wider utilization of staff nurses' organizations in hospitals to assist in policy formation, drafting of personnel policies, et cetera, and for the institution of better orientation programs for new staff members, and more effective continuing programs for in-service education. It was noted that some smaller hospitals may have an economic problem in offering nursing personnel salaries which are comparable with those paid in larger centres.

D. Other Problems

It was observed that in many hospitals conducting schools of nursing, nursing education and nursing service are not sufficiently co-ordinated. Also, hospital policies are not always clearly defined, which adds to the problems of nursing service administration. The nurse administrator in the smaller hospital has many duties involving hospital administration as well as those of direction of the nursing service. Problems are accentuated if the hospital has no medical director,

(Continued on page 74)

Shown here are leaders at the Nursing Administration Work Conference. Sitting: Margaret Street of Calgary, director of the conference; Evelyn Mallory, director of the school of nursing, U.B.C.; and Ruth Morrison, representing the Registered Nurses' Association of B.C. Standing: Evelyn Hood of the R.N.A.B.C. and Lorna Horwood, assistant professor, U.B.C. school of nursing.

One Hospital's Experience With

People and the Supplies They Use

Sidney Liswood, M.B.A., M.P.H.
Administrator
and
George J. Riesz, B.A.
Administrative Resident
New Mount Sinai Hospital.
Toronto, Ont.

THE FIRST patient was admitted to the New Mount Sinai Hospital two years ago. Much has been achieved in these two years: old employees had to become accustomed to a new environment; new employees had to adjust themselves to the hospital's atmosphere; and both were expected to adapt to new concepts. The occupancy of our 331 beds rose gradually to over 90 per cent after 18 months.

People are the most important part of any organization. Thus, two years had to elapse before we could afford to pay serious attention to the secondary problem of the supplies. But even while the supplies were being considered, those working with them and using them could not be forgotten.

The administrator appointed the comptroller, the purchasing agent and the administrative resident, to form a committee, co-ordinated by the assistant administrator, to ascertain and to remedy the uses and abuses of supplies stored and issued in the hospital. The intention was not to impose a system management would find feasible, but to work one out, with the participation of everyone concerned, which would meet the needs of our organization and our patients.

Evaluation of Previous Situation

The stores of the New Mount Sinai Hospital were said to be "functioning smoothly". There were no important complaints regarding receipt and distribution of goods and, thus, no interdepartmental friction; the staff was large enough to handle the occasional peak periods of demand; no shortage of any nature was ever discovered or suspected; and staff turnover was lower than average. Even when the department head was asked to look after another department as well and, subsequently, when he left, the lack of supervision had no apparent consequences. So there seemed to be no great need for change.

When a few danger signals appeared, they were attributed to other departments. When the perpetual inventory system broke down, the blame was placed entirely on the accounting office. When unneeded supplies were seen to be accumulating, the tendency was to chalk it up to the lack of "tradition" and routines in the new institution, to indiscriminate purchasing or to the turnover in key positions in other departments. Unusual requisitions were explained by a large variety of excuses.

Some occurrences, however, had no ready-made excuses. The physical setup was obviously poor but the workers got used to it and did not complain. The monthly figures of expenses varied substantially without explanations. During the short period while the accounting department kept inventory records, the figures did not agree with partially duplicated records kept by the stores and the purchasing office; nor was the purpose of the duplication explained.

Only on close analysis could it be discovered that the missing element was a system of over-all control and co-ordination. Purchasing cannot be efficient without control of consumption or at least some information about it. Naturally, we had some control measures in the past. The comptroller occasionally took physical inventory of selected items, checking the quantities against receiving and distribution records. Requisitions had to be approved by the department heads and, for the sub-departments of nursing, by the director as well. Minimum and maximum storage quantities were established, based on a short period of observation, to guide purchasing.

The various measures, however, had never been worked into an efficient single system.

Planning

In general, the committee agreed to work out a plan to provide for exchange of information between the departments in such a manner that errors and discrepancies should be immediately *noticed* (not just noticeable) and timed to make possible an even flow of work.

The basic tool is a perpetual inventory system. It was felt that employees of the stores, accounting, and purchasing departments should take part in maintaining these records, so as to make collusion more difficult and to obtain virtually triple-checked data, without triple effort. All departments were notified and asked to give us suggestions to improve their relationship with stores.

Analysis

It was decided to take a complete inventory and to investigate *why* we stored what we kept in stock. Most of the items carried had their consumption histories for six months. These were carefully reviewed and, though the records were inaccurate and even the quantities actually used could not be considered reliable due to changes in bed occupancy and capacity, the study was very revealing.

The analysis was supplemented by a comparison of the latest inventory balances with previous ones. Three problems became immediately evident:

(a) The minimum and maximum quantities to be stored (established about a year ago) were obsolete;

(b) Many commodities stored were not used at all; and

(c) Departments engaged in identical work (e.g., two surgical nursing units) were requisitioning different supplies and the same supplies in significantly varying quantities.

At this stage the "consumers" were involved in the program. The heads of the departments, in a series of conferences, reviewed the use of all stock items. This move resulted in the creation of excellent co-operation so that far-reaching objectives were worked out smoothly and rapidly.

First of all, agreements were reached on eliminating storage of a large number of items. Out of 176 different types or sizes of catheters, for instance, it was found that only 86 are needed. Similarly, certain kinds of sutures, dressings, paper products and other items were found unnecessary. This was a first major step towards standardization and we decided to protect this attitude and to stimulate it further by the system which would evolve from this study.

With the co-operation of department heads, new minima and maxima

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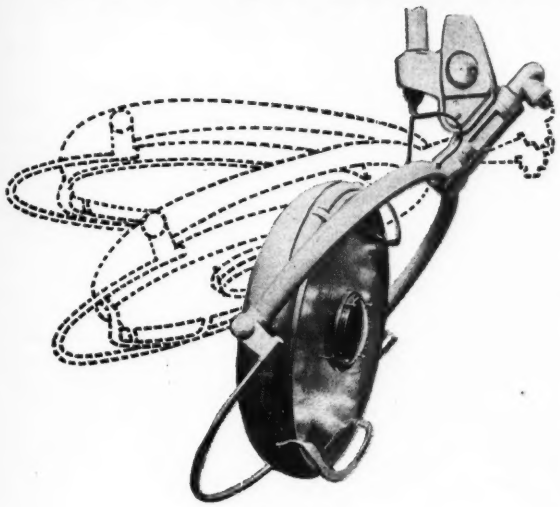

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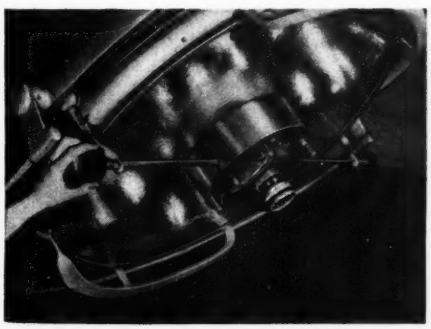

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were established for all items, considering consumption and such factors as storage space available, quantity purchasing, deterioration, possible emergency needs, and cost.

Some of the unused items we decided to return for credit; others the departments were willing to consume. Now we were ready for housecleaning, to be followed by installation of the new system.

Physical Set-Up

Accessibility and ease of control were two important factors to be considered in re-arranging the storage space, aside from obvious factors such as ease in cleaning the area, frequency of issue and optimum temperature.

Wherever feasible, the items stocked were arranged in the same numerical order as our inventory code. The space allotted to any item was labelled to show code number, name, and minimum and maximum levels of storage in order to enable the clerks to tell by a glance if purchasing discrepancies arose.

Purposes of System

While the basic objective, making the supplies necessary to operate the hospital available to those who used them, was not forgotten, it had to be analysed to be of use. Thus, we found the following objectives desirable:

1. to avoid shortage of essential supplies at any time;
2. avoid storing unneeded merchandise;
3. stock goods in reasonable quantities only;
4. to provide prompt information for purchasing and accounting in an even flow;
5. to time distribution so as to even the work load;
6. provide the departments with a simple requisitioning system; and
7. to control the requisitioning.

The System

Distribution of supplies to the departments is the only function where timing can be controlled, though not without difficulties.

The central supply service and the dietary department, due to their limited storage space, submitted daily requisitions, with the exception of Sundays. They now order double quantities on Tuesday, thus freeing Wednesday to issue supplies to the nursing stations (previously started on Monday but often not completed by Wednesday). The housekeeping department agreed to requisition twice weekly instead of three times and will soon requisition their supplies weekly.

It is impossible to control the timing of receiving but, as experience proved Friday to be the busiest day of the week, distributions are to be held to a minimum on this day.

Perpetual Inventory entries are made on Monday and Thursday to enable preparation of shortage lists by Tuesday and Friday for dietary and medical supplies respectively. Receipts are entered in the inventory daily by the stores secretary. Entering the issues and preparing shortage lists are combined into a single operation, handled by the purchasing secretary. The accounting office enters the values and audits the entries of the other two departments.

Actually, there is a bit of duplication or lack of "streamlined" procedure here, as receipts and prices could be entered simultaneously with the saving of a considerable amount of work. We decided, however, that this simplification is *not* desirable because it eliminates an important control measure and because the inventory records could not be kept up-to-date.

The Method used had been chosen for its simplicity. The basic record is the inventory card, which carries the following data: name of item, code number, units of issue (and quantity or weight thereof), units of purchase, minimum and maximum quantity to be stored.

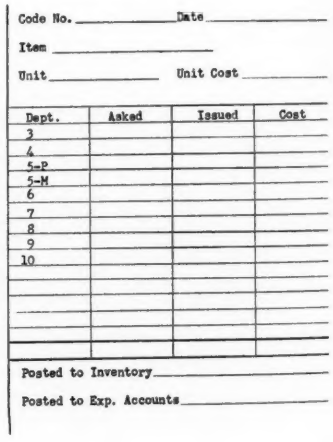
Columns are set up for the following: date of transaction, reference (name of vendor and purchase order number or name of requisitioning department), quantity received, value of receipt, quantity issued, value of issue, balance (quantity and value), unit cost (average), and brand name of article (shown only if variation is possible).

Requisition forms are preprinted for each department, listing the routine stock items used by the particular department, the units of issues and their sizes, the code numbers, the quantities ordered and received. A column, where the department is to show the quantities still on hand, is hoped to serve as a psychological deterrent to hoarding.

Reliable consumption figures will be available when the inventory system will have been in operation for at least six months; then average consumption figures will be established for each routine supply for each department. This will serve as a further control when related to patient days.

A small requisition summary form, as illustrated, had been drawn up to

(Continued on page 94)



Code No. _____ Date _____

Item _____

Unit _____ Unit Cost _____

Dept.	Asked	Issued	Cost
3			
4			
5-P			
5-M			
6			
7			
8			
9			
10			

Posted to Inventory _____

Posted to Exp. Accounts _____

Daily Procedures

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Stores clerks	Issue to Dietary C.S.R. Receiving	Dietary C.S.R. Lab, x-ray, etc. Housekeeping Receiving	All nurses' stations Blood bank O.P.D. Receiving	Dietary C.S.R. Receiving	Dietary C.S.R. Housekeeping Receiving	Dietary C.S.R.
Stores sec'ty		Prepare requisitions Daily: File purchase order copies Enter receipts to inventory Enter requisitions	Help issuing			
Purchasing	Enter issues of food	Food purchasing	Enter issues of Housekeeping supplies	Enter issues of medical supplies	Purchase of medical supplies	
Accounting			Enter prices (food)		Enter prices (medical supplies)	

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Hospital Dietetics in Ireland

Patricia Beckwith,*
Dietitian,
Queensway General Hospital,
Toronto, Ont.

THERE ARE 1,350 beds and three dietitians in the Belfast City Hospital, Northern Ireland. To a Canadian dietitians this sounds a ridiculously low number. However, it is partly explained by the fact that the term "dietitian" has a specialized meaning in Ireland. It generally refers only to dietitians dealing directly with patients on special diets, whether in hospital or attending as out-patients.

The Belfast City Hospital, originally part of the workhouse, has developed rapidly since the introduction of the National Health Service. Apart from the medical and surgical wards of the main unit, there is a children's hospital; two buildings deal with maternity and gynaecological cases; there is a progressive geriatric unit, and separate buildings house the skin cases, and people with nervous disorders. Special departments, such as dietetics, physiotherapy, et cetera, serve all these units, and even the general catering may be centralized eventually.

The general catering of the hospital is left to those specially trained for this work. This department supplies meals to the patients on ordinary, light and soft diets, to the doctors' and nurses' residences and to a staff canteen. Thus the dietitians are left free to concentrate their interest on therapeutic diets and, perhaps, to see the planning of the meals from a patient's point of view rather than from a buyer's. There is a special kitchen under the control of the chief dietitian, where up to 170 diets, as well as large quantities of special milk feeding, are prepared daily. The chief dietitian is responsible for the entire management of the special kitchen including the engaging of staff, ordering of equipment and food, planning of menus, supervision of cooking, serving, et cetera. One of the greatest difficulties is the recruitment of suitable staff, as the salaries for cooks are very low. The cooks in a diet kitchen are, as far as possible, girls holding certificates from cooking schools for courses of various lengths and who are particularly interested in hospital work. The dietitian will also advise on the nutritional aspects of the general hospital dietary provided for patients and staff; she is responsible for lecturing and/or demonstrating to nurses, medical students and groups of patients on normal nutrition or therapeutic dietetics. She also consults with the medical staff on problems of individual or collective feeding, and on investigations involving special knowledge of nutrition.

The work of a therapeutic dietitian in Belfast City Hospital involves keeping a day by day record of all patients on diets, of any changes in diets, comments made by the nursing staff, extra nourishment supplied, et cetera. Ward rounds are made each morning, at which time new patients are visited and the diet explained before the noon meal when the majority of diets are started. Diets ordered after noon, except for emergency ones, are held over until the following day. Patients who are being discharged on diets are instructed and given an appointment to see the dietitian in the out-patient department. All cases are discussed with the sister in charge of the ward for her daily observations on conditions, and new diets are talked over with the doctor. The usual routine of administration, checking the diet kitchen, menu planning, and teaching are carried on as required.

This hospital has a busy "extern" department where patients are referred from the medical, surgical, gynaecological, orthopaedic and paediatric clinics to the dietitian. Diets are given and appointments made for follow-up work even if the patient is not attending other clinics. Patients discharged from the hospital on diets are seen as many times as required, without further reference to the doctors, unless requested. The dietitian works closely with the almoner (social service worker) to make recommendations about patients' dietary needs, or to enlist her help for patients who would otherwise have difficulties in financing the diet.

The conception of a dietitian as one who works only in the very specialized field of therapeutic dietetics is gradually changing in the United Kingdom. Her work is recognized in the field of catering for hospitals, schools and residential establishments, in advisory and survey work, in various aspects of the work of central and local government, and in the international field. To meet the need for dietitians with such varying backgrounds, the British Dietetic Association has adopted the deliberate policy of recognizing a number of preliminary qualifications in pure science, nursing, teaching, and in institutional catering management, for those who wish to take further training to qualify as dietitians, as well as approving special integrated courses for those who wish to become dietitian caterers. (Membership in the Canadian Dietetics Association is recognized for this branch.) Dietitians who qualify in any of these several ways share equally the privileges of full membership in the association. There is a suggestion that "every hospital of 150 beds or more should have its qualified dietitian responsible only to the medical superintendent" and further "that large hospitals of about 500 beds or more would require a number of junior dietitians as well as a senior one". There is, however, a great shortage of dietitians qualified for both therapeutics and catering, and neither is it anticipated that all dietitians will be interested in doing the combined job.

As a Canadian dietitian spending three months in this Belfast hospital, I appreciated the opportunity of working there, learning their methods, and bringing back ideas which will be of value in my work here. I bring back, also, memories of the beautiful countryside, and of the welcome I received from the charming Irish people.

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References

The British Dietetic Association Inc., Sept. 1955 B.D.A./4.

The British Medical Journal, 1945, Vol.II p. 617.

Emergency

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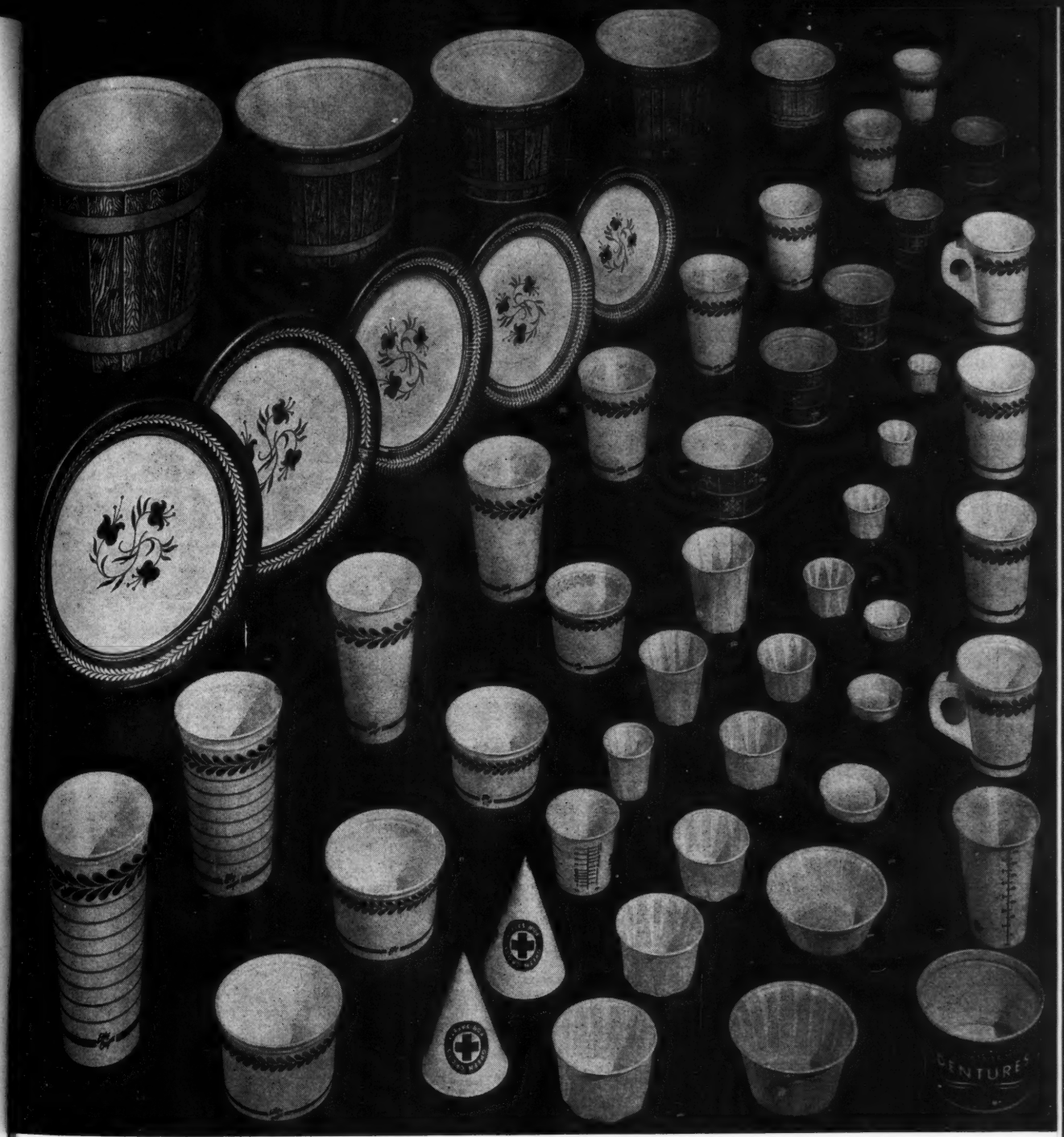
"Going out, dear?" asked his wife sympathetically.

"I'm afraid so," was the brave reply. "It's a very serious case. There are three doctors there already." *East Gen.*

By permission of A. Barbara McMahon, chief dietitian, Belfast City Hospital, Belfast, Ireland.



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Front row, left to right: L. Wilson, Drumheller, Alta.; V. J. Horejsi, Blairmore, Alta.; Mrs. A. Chisholm, Advocate, N.S.; Major M. Everett, Vancouver, B.C.; Miss M. S. Leithead, Winnipeg, Man.; Sister R. M. Prieur, Windsor, Ont.; Sister M. Priscilla, Peterborough, Ont.; Sister Helen Joseph, Broadview, Sask.; Sister Priscilla Marie, Vanderhoof, B.C.; Sister Marie-Michelle, l'Original, Ont.; Sister Rose Wilfrida, McLennan, Alta.; Sister M. Raphael, Toronto, Ont.; Sister M. Eugenie, Toronto, Ont.; Sister Philippa, Willowdale, Ont.; Miss M. E. McDowell, Bella Bella, B.C.; Mrs. L. Anderson, Oakville, Ont.; Miss M. Lambert, Cornwall, Ont.; Miss A. Uhrhammer, Greenville, S.C.; Z. J. Siemianowski, Garfield Hts., Ohio; F. S. Woodcock, Deep River, Ont.

Second row, left to right: H. H. Peddie, Iroquois Falls, Ont.; C. D. Wickenden, Toronto, Ont.; G. A. Stoll, Peoria, Illinois; K. F. Noton, Duncan, B.C.; A. E. Magis, Transcona, Man.; K. J. MacInnis, Kingston, Ont.; G. E. Chapman, Brandon, Man.; R. D. Moore, St. John's, Nfld.; J. B. McAulay, Toronto, Ont.; J. R. Donnell, Ste. Anne de Bellevue, P.Q.; R. D. McGugan, St. Catharines, Ont.; J. W. Mitchell, Columbus, Ga.; C. W. Hill, Toronto, Ont.; F. G. Hunt, Highland Creek, Ont.; P. Hodge, Terrace, B.C.; Lt. Col. R. B. Murray, Montreal, P.Q.; F. M. Cooper, Moose Jaw, Sask.; G. S. Lofthouse, Norway House, Man.

Third row, left to right: S/L J. B. Hardie, Ottawa, Ont.; J. A. McMillan, Port Alberni, B.C.; J. Sopotyk, Canora, Sask.; J. B. Thompson, Sardis, B.C.; F/Lt. T. Gerein, Rockcliffe, Ont.; R. A. Williams, White Rock, B.C.; J. R. Godbout, Halifax, N.S.; Major W. R. Dalziel, Oakville, Ont.; B. H. Foster Edmonton, Alta.; E. Dubinsky, Winnipeg, Man.; F. B. Gadsby, Kitchener, Ont.; N. M. Singleton, Winnipeg, Man.; C. C. White, Belleville, Ont.; R. E. Mann, Ingersoll, Ont.; S. J. Johnston, Windsor, Ont.; Dr. W. C. Wood, Hamilton, Ont.; J. W. Brydges, Woodstock, Ont.; P. M. Breel, Simcoe, Ont.

Absent when picture was taken: G. Charron, Arvida, P. Q.; L. Lacoste, Montreal, P.Q.

Bed Needs

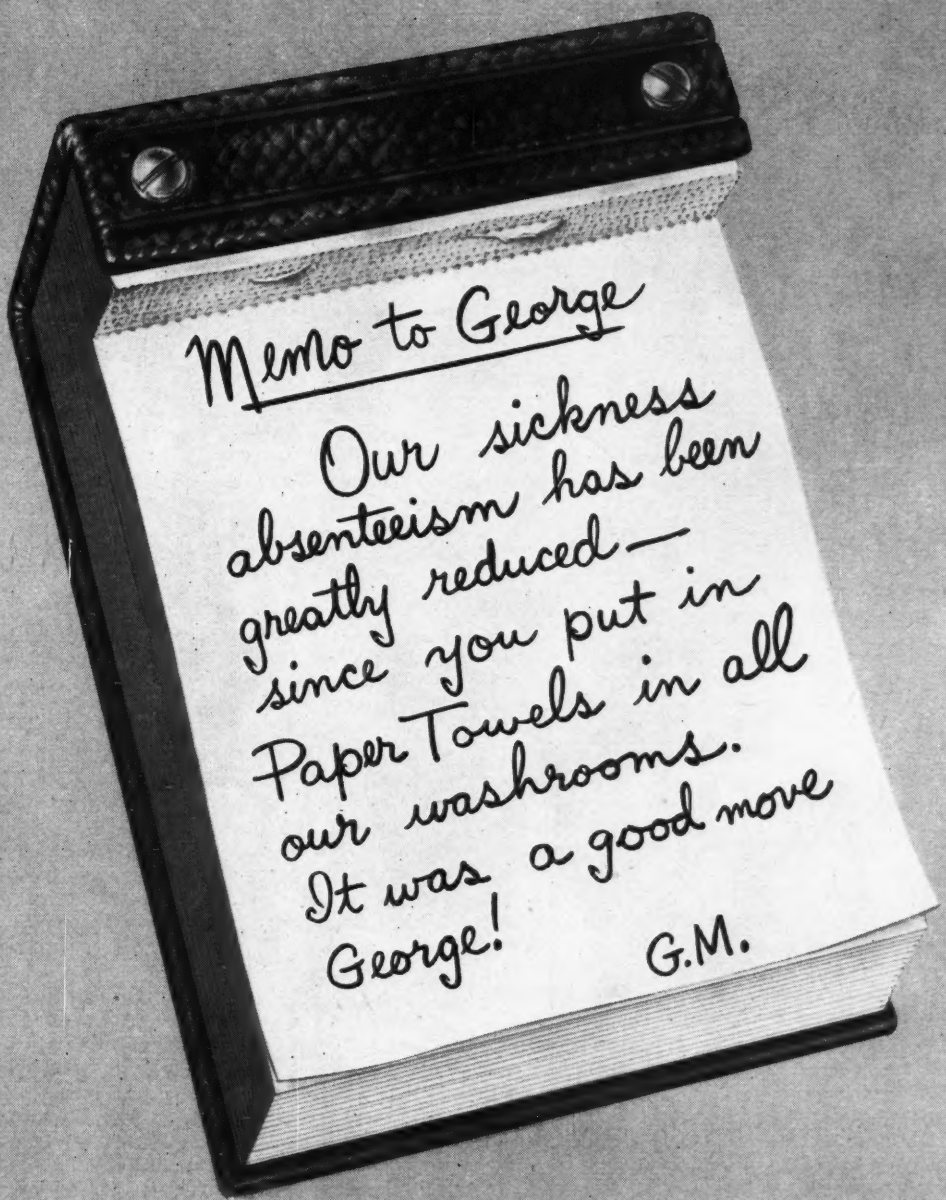
(Continued from page 37)

residents of these communities will vary with many social and biological factors. The incidence and prevalence of disease and the age composition of the population will obviously influence hospital admission rates. Other important social, geographic, and professional factors have been mentioned earlier. In a philosophical sense, one can say that whenever there is a hospital admission, it is because of a human need —even though that need may be psychological, a matter of casual convenience for the doctor or the family, or for other reasons which conceivably represent an extravagant use of community resources and funds.

The task is to take reasonable account of varying social and human needs among population groups, yet to reduce excesses by some standard based on *average* experience. The best manageable standard so far discovered for taking account of justified differences in hospital admission rates is the community's *rural-urban character*.[6] In other words, a highly rural section tends to be one with greater distances between patient and doctor, a smaller ratio of doctors to population (so that the doctor has less time per patient), poorer housing (so that care of the sick at home is difficult), and fewer diagnostic facilities for ambulatory patients. Under hospital insurance, these factors increase hospital utilization among rural and village people compared with populations of large cities. On the other hand, there is a high proportion of aged and feeble persons in the small towns and villages, with greater biological needs for hospital care, compared with hardier residents of the open country. Moreover, the residents of small towns, where living conditions are very humble and diagnostic facilities poor, undoubtedly see the doctor more often than do the outlying farm families served by the same doctor, so that hospital admissions can be more frequently ordered.

The resultant pattern in Saskatchewan is a hospital admission rate that is relatively low in the cities (5,000 population and over) at 174 admissions per 1,000 persons per year. In the open country rural districts, the rate jumps to 205 admissions per 1,000. In the small towns (500 to 5,000 population, but usually about 1,000), it is 230 admissions per 1,000 and in the villages (under 500 population), it is 243 admissions per 1,000. These are *average* rates for the province as a whole. By applying these rates to the cities, towns, villages, and open country areas within the apportioned population of any hospital, local deviations in way of over-use or under-use of hospitals can be corrected, so that all communities of a given demographic character are treated equitably. Thus each hospital is permitted to have sufficient beds to meet the needs of the

(Continued on page 62)



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First Year Students Attend Summer Course

These first-year students attended the Canadian Hospital Association extension course in hospital organization and management, held this year at Huron College, University of Western Ontario, London, Ont.; from June 4th to 26th. For second-year students, see page 60.

Front row, left to right: G. W. Stark, Ottawa, Ont.; A. G. Rodgers, Sidney, B.C.; Mrs. S. J. Fleck, Dalhousie, N.B.; Mrs. E. L. Spencer, Huntsville, Ont.; Sister A. Allain, Tracadie, N.B.; Sister M. Imelda London, Ont.; Sister St. Paul, Sarnia, Ont.; Sister V. Callaghan, St. Catharines, Ont.; Sister Ste. Laure, Shawinigan Falls, P.Q.; Sister M. Paula, North Bay, Ont.; Sister Mary, Barrhead, Alta.; Sister Anita Roy, Campbellton, N.B.; Sister L. Hevert, Tracadie, N.B.; Sister M. Lucita, Victoria, B.C.; Sister M. Anegs, Glace Bay, N.S.; Sister Paul of the Cross, Charlottetown, P.E.I.; Sister M. Annunciata, Humboldt, Sask.; Sister M. Fabian, St. John's, Nfld.; Sister E. MacPherson, Kingston, Ont.; Miss H. J. Lynds, Newcastle, N.B.; Miss W. R. Allan, Cochrane, Ont.; F/O J. MacGillivray, Sydney, N.S.; W. F. Thompson, Peterborough, Ont.; J. L. Manz, Prince Rupert, B.C.

Second row, left to right: R. F. Lawrence, Ottawa, Ont.; B. L. Baldridge, Provost, Alta.; G. Massue, Montreal, P.Q.; Dr. C. A. Roberts, Ottawa, Ont.; A. J. Bohnen, Toronto, Ont.; A. C. Cross, Viking, Alta.; F. W. Lamb, Red Deer, Alta.; K. G. Turner, St. Catharines, Ont.; Lt. Col. P. A. Costin, Barriefield, Ont.; J. R. Bryan, Welland, Ont.; A. M. Keefler, Hamilton, Ont.; G. A. Armstrong, Eastview, Ont.; J. A. Syme, Victoria, B.C.; M. MacDonald, Glace Bay, N.S.; M. C. Haw, Brantford, Ont.; A. R. C. Moores, St. John's, Nfld.; R. K. Travis, Kingston, Ont.; Lt. E. Y. Porter, Ottawa, Ont.

Third row, left to right: H. W. Smith, North Bay, Ont.; Dr. M. Thibault, Montreal, P.Q.; B. L. Vanderguard, Regina, Sask.; D. D. Thornton, Toronto, Ont.; L. J. G. Cantin, Quebec, P.Q.; J. R. Ellison, Edmonton, Alta.; P. Ratushny, Kamsack, Sask.; F/Lt. G. B. Manderson, Ottawa, Ont.; Wm. O'Neill, Saskatoon, Sask.; L. O. Peterson, North Dakota; W. C. Duncan, Halifax, N.S.; C. R. Elliott, Saskatoon, Sask.; J. Gentleman, Whitehorse, Yukon; J. Glenwright, Westview, B.C.; C. F. Lavery, Kelowna, B.C.; E. J. Campbell, St. John's, Nfld.; N. M. Thomson, Toronto, Ont.; W. C. Speare, Quesnel, B.C.; J. B. Davis, Ottawa, Ont.; W. A. Hume, Orillia, Ont.; H. Posyniak, Moose Jaw, Sask.; R. D. McGregor, Central Butte, Sask.; J. J. Cunningham, Banff, Alta.; A. W. E. Pitkethley, Victoria, B.C.

Bed Needs

(Continued from page 60)

particular urban-rural spectrum of its apportioned population, as adjusted to provincial averages. These average admission rates are, of course, computed anew each year, as is the spectrum of rural-urban composition of each hospital's apportioned population.

Beds Used by Non-beneficiaries

A final correction factor must be introduced into our calculations of bed needs, made necessary by the fact that our data is based on Hospital Services Plan records. These account, indeed, for well over 90 per cent of all hospital admissions, but there are a few hospitals — near the borders of the province or near Indian reservations — which may admit a much larger percentage of non-S.H.S.P. patients. Yet, these hospitals and, of course, all others to a lesser degree—need beds to serve these non-beneficiaries. Although S.H.S.P. payments are not made on behalf of non-beneficiaries, hospital staffing, equipment and beds provided must be enlarged by a degree sufficient to serve these persons. Accordingly, the apportioned population of each hospital is enlarged by the small percentage necessary to take account of these non-beneficiaries, based on admission records submitted annually by each institution.

Summary of Bed Need

In summary, then, the *bed need* of each hospital in the province can be expressed by a relatively simple formula:

Bed need of Hospital h = total apportioned population of hospital h x 7.5/1000 x *length of stay correction* of this size hospital x rural-urban adjustment of the composition of this apportioned population x coefficient of non-beneficiaries.

An example of this calculation, as applied to a hospital on the basis of experience, is given in Table 1.

This calculation of *bed need* is made each year for every hospital in Saskatchewan. In practice it is not so complex as it may seem and, with the basic formula worked out, the calculations are carried out by statistical clerks, under supervision.

Practical Administrative Adjustments

The figure for *bed need* provides the foundation from which the recommended occupancy of each hospital is estimated for budget purposes. In practice, it is not always possible to take 80 per cent of *bed need* and mechanically establish this figure as the recommended occupancy for which the costs of staff and other resources are to be provided. Flexibility is necessary to adjust to the physical realities of each hospital. Where the *bed need* is greater than the hospital's measured capacity, it may be necessary to allow occupancy at a percentage higher than

(Continued on page 90)

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Provincial Notes

British Columbia

ASHCROFT. A new $70,000 wing of the Lady Minto Hospital was opened recently by L. B. Dunsmore, chairman of the hospital board. The hospital was first incorporated in 1912, and serves a wide area.

CAMPBELL RIVER. Construction is underway at the new Campbell River and District Hospital. A Nanaimo construction company has been awarded the contract to build the 66-bed hospital.

GOLDEN. The first phase of Golden General Hospital's improvement program culminated recently in the formal opening of the new $30,000 Nurses' Home, which is now in full use.

FORT ST. JOHN. Plans that call for a 63-bed addition to the Providence Hospital are under consideration; they may include provision for a further addition of 28 beds.

TRAIL. It is expected that the demolition of the old Trail - Tadanac Hospital will be completed by September, at a cost of $15,450.

VANCOUVER. A modern 50 - bed chronic and convalescent hospital, the Edith Cavell Hospital, was opened recently by a group of doctors. Private, semi-private, and 4-bed wards are available, each with a large picture window, terrazzo floors, and comfortable appointments. Bathrooms are of a unique design, with the tub in the centre of the floor. The superintendent of this new hospital will be Mrs. Mayme Spencer, R.N.

Alberta

CAMROSE. Grants have been awarded for the expansion plans of the Rosehaven Hospital. A new frame and stucco building of two wings of 25 beds each will provide day room and dining room accommodation; and a new dormitory addition will provide accommodation for 46 patients, with related facilities.

INNISFAIL. Work has commenced on an $18,446 project for a new front and renovations to the Innisfail Municipal Hospital. An improved appearance will be aided by suitable landscaping, while the hospital's efficiency will be increased by the addition of a waiting room, secretary's office, facilities for the storage of records, and showers for members of the medical staff.

Saskatchewan

EATONIA. The Eatonia Union Hospital Board has proposed to build a new hospital, concerning which questionnaires have been sent to all ratepayers in the district. The present inadequate layout of hospital and nurses' residence would be replaced by a new hospital costing approximately $90,000.

MELVILLE. An extension costing $260,500 is being planned for St. Peter's Hospital, it was announced recently, that will increase its capacity from 44 to 70 beds. It is hoped that the new total may be as large as 80 beds.

SASKATOON. Work on the completion of the top floor of the Nurses' Training School of St. Paul's Hospital is scheduled to be completed in September. This project will provide an extra 30 bedrooms for student nurses, an extra classroom, demonstration room, and increased library facilities.

WEYBURN. The latest addition to the Saskatchewan Hospital, a $400,000 tuberculosis wing, was opened recently. The new wing is a three-storey brick building with sun deck 163 feet long; all floors and stairs are faced with terrazzo; and a complete air conditioner and climate changer for the whole building has been installed. Weyburn is the centre for all mentally-ill tuberculosis patients in the province. The wing increases the capacity from 60 to 100 beds.

Manitoba

GRANDVIEW. The new 16 - bed Grandview General Hospital was opened by Dr. M. R. Elliott, Deputy Minister of Health and Welfare recently. New $8,000 x-ray facilities are included in the 146 ft. by 39 ft. building, the total cost of which was $140,000.

WINNIPEG. Some 220 student nurses have moved, recently, into the new $1,500,000 5-storey brick nurses' residence at the Winnipeg General Hospital. The building has features that include an auditorium to seat 450 with a unique oak tile floor, private rooms for the students, and private waiting rooms for visitors.

WINNIPEG. The new hospital wing of Winnipeg's Jewish Old Folk's Home was dedicated recently. A tour of the 34-bed patients' wing on the fourth floor of the home was also arranged. One outstanding feature is the solarium, completely glass-enclosed on two walls, the entire framework of which is of aluminum.

Ontario

CORNWALL. Community - minded men and organizations have banded together to save the new Hotel Dieu Hospital landscaping and seeding costs, for which a district firm had submitted a $25,000 price quotation. Working on Sunday and in their spare time, the Knights of Columbus and Coleman-Munro Limited have joined forces with the Hydro Electric Commission, in trucking topsoil, smoothing earth and seeding lawns.

DUNNVILLE. The handsome new one-storey nurses' residence, adjoining the Haldimand War Memorial Hospital, was opened recently. It has been named the "Maud B. Camelford Nurses' Residence".

HANOVER. The new $350,000 extension to the Hanover Memorial Hospital was opened recently. It will provide accommodation for an extra 46 beds, and 12 nursery bassinets.

KINGSTON. The first sod was turned recently on the site of the proposed Walter T. Connell wing, major project of the Kingston General Hospital's completion program. This projected new seven-storey building will add a total of 150 beds to the present 507-bed capacity, at an approximate cost of $3,600,000.

(Concluded on page 98)

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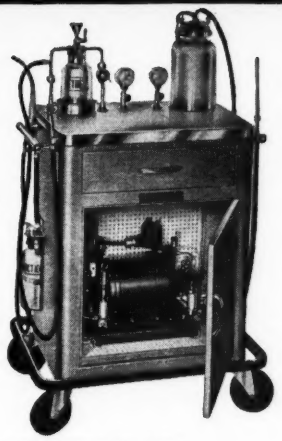

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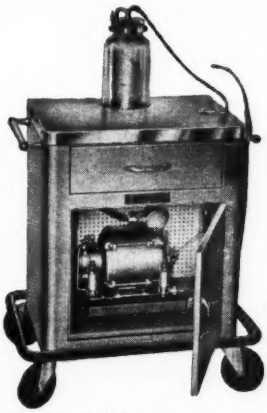

CSA APPROVAL NO. 11098

NEW IMPROVED PRINTZ MODEL SUCTION UNIT, CAT. No. 100-80.

Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

Printz Model, Cat. No. 100-87 (not illustrated) is same as 100-85 but equipped with separate rotary compressors for ether bottle and suction bottle.

CSA APPROVAL NO. 11098

NEW IMPROVED TOMPKINS MODEL SUCTION AND ANESTHESIA UNIT, CAT. No. 100-10.

Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. Tompkins Model for suction only, Cat. No. 100-15 (not illustrated) is equipped with two 32-ounce suction bottles and no ether bottle.

Standard color for all units is Sklar silver grey baked enamel.

DESCRIPTIVE LITERATURE ON REQUEST

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Western Canada Institute

(Concluded from page 51)

ed by the Canadian Mental Health Association to investigate mental health treatment services in Canada. Members of this committee, the speaker said, were convinced that closer liaison between the various medical specialties would be of advantage to patients of all types. In the opinion of this committee: psychiatric patients are entitled to the same standard of care as the general hospital patient; acute psychiatric patients should be treated in a medical centre; these units should be not larger than 300 to 500 beds in capacity; joint community planning for such patients is imperative now; and there should be a medical centre of the size mentioned for every 60,000 of the population. Dr. Swanson stated that improved standards of care for the mentally ill would materially cut down the incidence of chronic mental illness in the general population.

Federal Health Insurance Proposals

Current federal health insurance proposals were discussed by Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association, who reminded his audience that any national plan, as such, was restricted by the terms of the British North America Act under which health was set down as a provincial responsibility. At the last Dominion-Provincial Conference, he recalled, the federal government had announced that when any six provinces, representing the majority of the population of Canada, were prepared to inaugurate a plan of hospital insurance in their respective provinces, the federal government was prepared to assist them financially. The basis of payment would be 25 per cent of the national average cost and 25 per cent of the provincial average cost. The federal proposal pertained only to hospital care for the acutely ill and long-term patients, exclusive of the mentally ill, tuberculosis cases, and those cared for by Workmen's Compensation Boards. Nor does the federal government propose to assist with the cost of administering provincial plans.

Three provinces, British Columbia, Saskatchewan, and Alberta, had already signified their willingness to cooperate with the federal government in such a scheme and it is quite possible, Dr. Piercey pointed out, that we may eventually have ten provincial plans, differing somewhat from each other but all receiving federal financial support. The speaker emphasized that the autonomy of individual hospitals was not at stake but that, at the provincial level under a government-sponsored plan, a closer measure of government control might well be expected.

Iowa Decision

Dr. Edwin L. Crosby, director, American Hospital Association, outlined the implications of a decision handed down by a district court in Des Moines, Iowa, which if not reversed by the State Supreme Court may have an adverse effect upon hospitals in other states and other countries. The case was one filed by the Iowa Hospital Association against the Iowa State Board of Medical Examiners, the Iowa Association of Pathologists, and the Iowa State Medical Society, in seeking to establish the right of hospitals to own and operate laboratories. After a long and involved trial, Judge C. Edwin Moore ruled that it is illegal for hospitals in Iowa to employ physicians and charge patients for their services. The court concluded that "the work done by the pathologist, radiologist, and the technicians . . . constitutes the practice of medicine; . . . that the plaintiff hospitals . . . have been engaged in unauthorized, unlicensed and illegal practice of medicine."

If this decision is upheld, Dr. Crosby said, it will mean that hospitals will have no voice in the choice of technicians and no control over laboratory work. It will mean multiple billing of patients, a general increase in the cost of care to patients, and a further upgrading of specialists' fees. There would also be loss of income to hospitals. The decision opens the door to many vexing problems, said Dr. Crosby, citing the status of resident physicians, interns, and therapists. The fight has been one for the control of certain traditional hospital services. It is now before the Supreme Court of Iowa and hospital people everywhere await with some concern the disposition of the appeal. Dr. Crosby indicated that many questioned the wisdom of ever allowing the case to be brought to court.

For Trustees

Under the chairmanship of Fred Fisher, chairman of the board of Vernon Jubilee Hospital, Vernon, B.C., a panel discussion was held on the subject "Should a practising physician be a member of a hospital board?" Those taking part were J. A. Abrahamson, chairman of the board, Queen Victoria Hospital, Revelstoke (and also president of the British Columbia Hospitals' Association); Dr. Palmer McLean, New Westminster; Dr. W. H. Sutherland, Vancouver; Mrs. G. C. Chandler, chairman, Trustee Division, B.C.H.A.; and Dr. Edwin L. Crosby of the American Hospital Association.

Dr. Crosby strongly urged a joint conference committee to work in liaison between the organized medical staff and the hospital board but did not, on the whole, think it advisable for a practising physician to be a board member. Mrs. Chandler pointed out that physicians and board members have a common object *i.e.* achieving harmony and efficiency within the hospital. Board members, she believed, should be people with broad experience and not, preferably, active in any of the professions within the hospital field. The speaker gave it as her opinion that no practising physician should be a board member. Both Dr. Sutherland and Dr. McLean favoured, in fact urged, that medical staff be represented on governing boards. However, as Mr. Ward pointed out, the physicians present did not ask that the medical staff representative be a voting member of the board.

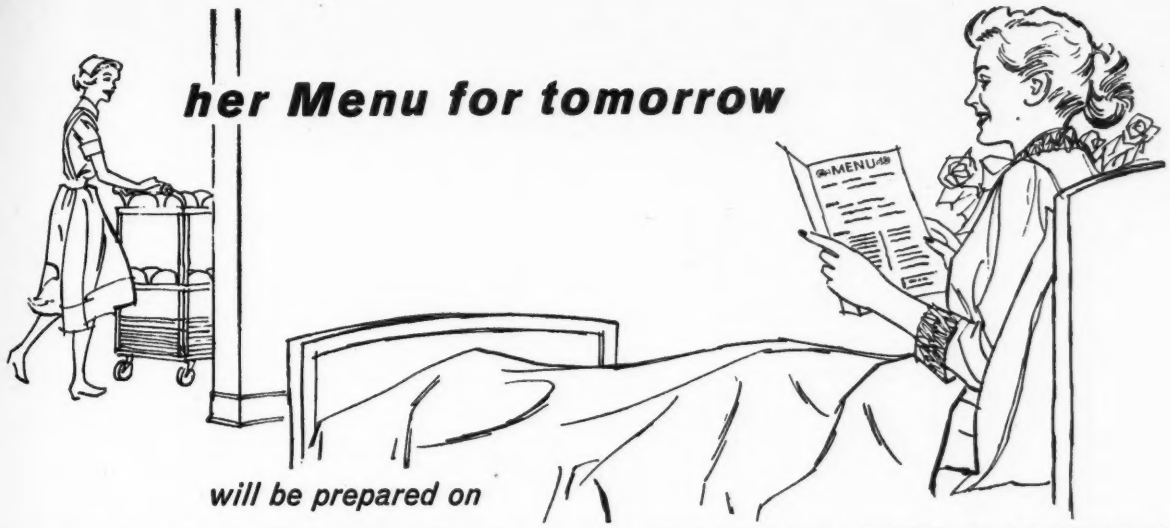
Subsequently a second panel discussion was held to deal with topics of special interest to trustees. Mrs. G. C. Chandler acted as moderator and the faculty-at-large answered questions ranging from how many members there should be on a governing board and how long the term of office should be — to providing educational opportunities for the administrator and other key personnel.

And Also . . .

An interesting feature of the institute was an opportunity to visit hospitals on the lower mainland, for which special transportation arrangements had been made. At St. Vincent's Hospital, St. Paul's, the Children's Hospital, and Burnaby General Hospital, guides conducted visitors through various departments and tea was served before the return journey. Then, too, the banquet which was held in Brock Hall on the campus was enjoyed by all. This event was arranged by the Women's Auxiliaries Division of the British Columbia Hospitals' Association.

At a luncheon meeting of the coordinating committee (which included representatives from the four western provinces), it was decided that the 1957 institute would be held in Saskatoon, immediately following or partly coinciding with the biennial meeting of the Canadian Hospital Association. The dates are not yet definite

There was widespread approval of the type of program presented this year in Vancouver and those who attended, appreciating that panel discussions are not easily arranged, were most grateful to the local committee for the smooth functioning of all sessions. A special vote of thanks went to Percy Ward, secretary of the British Columbia Hospitals' Association, and to his assistant, Mrs. Edith Pringle, who acted as registrar for the institute.●



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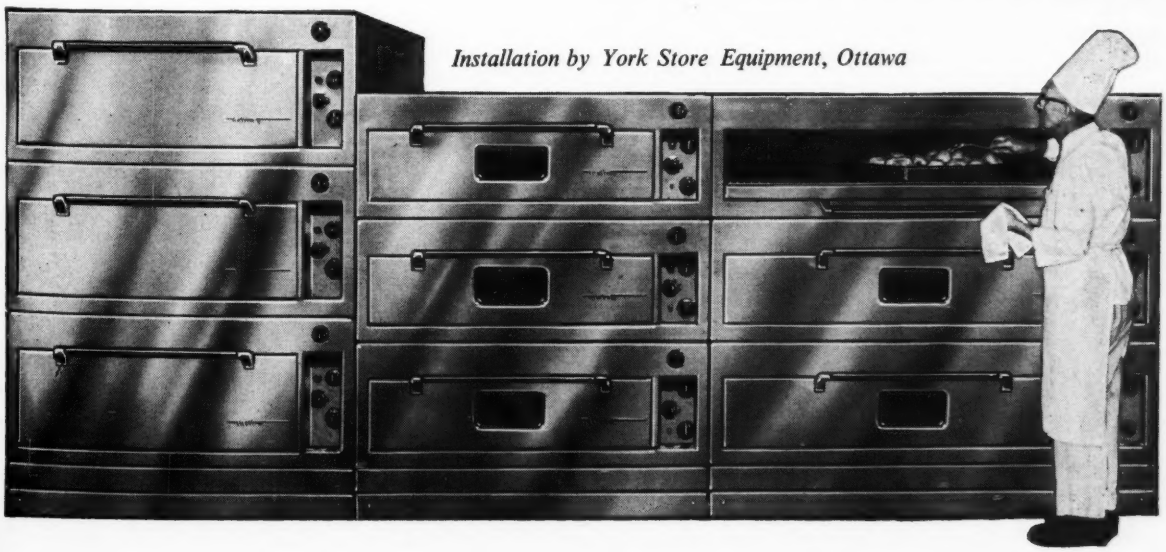

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Laundry Managers Meet in Toronto

Left to right, front row (seated); Jack Cluff, Sunnybrook Hospital, Toronto; Fred George, Hamilton General Hospital; Al Rudd, Royal York Hotel, Toronto; Harry Shea, Toronto General Hospital; Sam Corbett, The Hospital for Sick Children, Toronto. Centre row: Larry Kushluski, St. Joseph's Hospital, Toronto; Reg Stott, Oshawa General Hospital; Ellen Cowan, Toronto Western Hospital; S. J. Gadsby, Ontario Department of Public Health; E. A. Bell, Mountain Sanatorium, Hamilton; Gus Mayheu, Kitchener-Waterloo Hospital; William Powell, Sunnybrook Hospital, Toronto. Back row: John Lisafeld, Grace Hospital, Toronto; Dick Lawson, Toronto General Hospital; George Digby, New Mount Sinai Hospital, Toronto; Tom O'Leary, Royal York Hotel, Toronto; Stan Hierons, Kitchener-Waterloo Hospital; Joe Hersey, Ontario Agricultural College.

Laundry Managers Organize

Two organizational meetings of institutional laundry managers are of interest to the hospital field. The group from western Ontario met at the Kitchener-Waterloo Hospital, Kitchener, Ontario, on April 26th. S. Hierons of Kitchener-Waterloo Hospital was elected as president, S. Tracy of Westminster Hospital, London, as secretary-treasurer, and Joseph Hersey of the Ontario Agricultural College, Guelph, as membership chairman.

The central Ontario group met at the Royal York Hotel, Toronto, on May 25th. A. E. Rudd of the Royal York Hotel was elected president; Harry Shea of the Toronto General Hospital, first vice-president; Fred George of the Hamilton General Hospital, second vice-president; Sam Corbett of the Hospital for Sick Children, Toronto, as secretary; and Jack Cluff of Sunnybrook Hospital, Toronto, as treasurer.

It is anticipated that other regional groups will be formed and that eventually a provincial organization will take shape as a division of the National Association of Institutional Laundry Managers. Managers of all laundries operating on a non-profit basis are eligible for membership.

The objectives of the groups are essentially educational. Periodic institutes or courses dealing with various laundry techniques will be conducted. Meetings of the groups will serve as media for the exchange of ideas and information.

As personal members of the National Association of Institutional Laundry Managers, the individuals will receive the monthly publication of the association entitled *Nail'm News* and other benefits of association membership.

17th Annual Convention

Catholic Hospital Conference of B.C.

The meetings of the Catholic Hospital Conference of British Columbia were held this year in St. Paul's Hospital Auditorium, June 9th and 10th, following Mass celebrated in St. Paul's Chapel. Sister Mary Ruth chaired the meetings at which approximately seventy delegates registered. Rt. Rev. Monsignor Joseph B. Brunini, Jackson, Mississippi, newly elected president of the Catholic Hospital Association of U.S.A. and Canada, was guest speaker both days. The following is the new slate of officrs who will assume duties on October 1st:

President: Sister Anne of the Sacred Heart, St. Paul's Hospital, Vancouver.

1st vice-pres: Sister M. Laureen, St. Joseph's Hospital, Comox.

2nd vice-pres: Sister St. Ives, Mount St. Joseph's Hospital, Vancouver.

Secretary: Sister Patricia Ann, St. Paul's Hospital, Vancouver.

Councillors: Sister Alexina, St. Vincent's Hospital, Vancouver; Sister Justinian, St. Joseph's Hospital, Victoria; Sister Jeannette, St. Joseph's Hospital, Comox; Sister Agatha, Mount St. Joseph's Hospital, Vancouver.

Tuberculin - Negative Group Rising

The growth of a predominantly tuberculin-negative population on this continent means a population with no acquired resistance, Dr. Stefan Grzybowski, of the Toronto Department of Health, declared at the annual meeting of the American Academy of Tuberculosis Physicians in Chicago.

Dr. Grzybowski cited a tuberculosis epidemic involving 19 active cases of tuberculosis in a township in northern Ontario. A heavy morbidity was observed in the 15-to-24-year-old group, one out of every 19 persons affected with clinically active tuberculosis being in this age group — a rate of 5.5 per cent.

Keep the local fire department advised of all changes in building layout, changes to buildings and structures, et cetera.

Notes on Federal Grants

Construction

A hospital construction grant of $40, 953 will aid the Victoria General Hospital, Halifax, N.S., to develop an out-patient and metabolism section.

A grant of $9,000 will help provide space for eight beds, operating room, and other facilities at the Union Hospital, Montmartre, Sask.

The Sherbrooke Hospital, P.Q., will receive a cancer conrol grant of $9, 777 to aid the setting up of a diagnostic and therapeutic clinic.

A general public health grant of $5,840 will assist in the establishment of a glaucoma clinic at Victoria Hospital, London, Ont. More than $34,000 has been granted for additions and alterations to increase accommodation by 26 active treatment beds and a new nurses' quarters of nine beds at the Lady Minto Hospital, Chapleau, Ont.

$30,050 goes to the new Community Hospital, O'Leary, P.E.I., which is under construction, to include 27 active-treatment beds.

A grant of $15,000 goes for a new health centre at East Penticton, B.C.; $51,500 has also been granted towards a nurses' home and training centre at Essondale, B.C. — where space will be provided for 103 nurses' beds, with conference, lecture, demonstration and practice rooms, as well as library, auditorium and administrative offices. $31,000 goes towards construction of the Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C., to assist in the creation of a new building for 25 active-treatment beds, 5 nurses' beds and other facilities.

$75,000 goes to Bethany Chronic Hospital, operated by the Evangelical Lutheran Church at Camrose, Alta., where provision will be made to accommodate 50 long-term patients.

Research

Grants of $8,675 and $8,086 respectively have been made to the Connaught Laboratories, University of Toronto, Ont., for studies in antigenicity of polio vaccine in humans, and a vaccine against tuberculosis; $5,626 goes to the University of Western Ontario, for research related to air pollution by fungal spores in connection with allergic diseases; $6,856 to Queen's University, Kingston, Ont., for a study on the role of fibrin in the development of arterio sclerosis; and $6,000 to Ontario for short training courses for medical rehabilitation personnel.

Psychology of Retirement

Commenting on the approval of a government contribution of $19,000 to McGill University, Montreal, P.Q., Health Minister Paul Martin noted that, during the past five years, the number of patients 70 years and over admitted for the first time to Canadian mental institutions had increased by about one-third. It is necessary, therefore, to obtain information on the causes of mental illness in the older citizen group. The study will concern itself with personal and social factors related to retirement adjustment and attitudes. The project will be directed by Dr. Ewen Cameron, chairman of the Allan Memorial Institute of Psychiatry at McGill, and the principal investigator will be Dr. J. S. Tyhurst. The study will last for two years.

Other Mental Health Provisions

McGill University, Montreal, P.Q., will receive a grant of $12,630 for studies concerning the neuro-endocrine relationships in the pituitary adrenal response to stress, and $11,000 for inquiries concerning automatic and adrenal functions in schizophrenia. These projects will be carried out at the Allan Memorial Institute. A further grant to McGill University is for $6,530 for group psychotherapy at the Montreal General Hospital in connection with asthma and other allergies.

A federal contribution of $6,380 goes to the University of Manitoba for research related to techniques for diagnosing mental diseases.

In Saskatchewan, follow-up studies of mental patients after hospital discharge have received grants of $4,488.

Grants totalling nearly $30,000 have been made to mental health studies to be carried out in the University of British Columbia's department of neurological research, under the direction of Professor W. C. Gibson. The research will seek to find further evidence of the relationship between physical factors and certain types of mental illness.

With the Auxiliaries

Auxiliaries Division B.C.H.A.

The twelfth annual convention of the Auxiliaries Division of the British Columbia Hospitals' Association was held June 13th to 15th at Brock Hall, U.B.C., to coincide with the meeting of the Western Canada Institute of Administrators and Trustees. Its theme was "Service" and Mrs. F. E. Atkinson was in the chair. The session was officially opened by Mr. J. A. Abrahamson of Revelstoke, president of the B.C.H.A.

Mrs. Forbes Perkins, immediate past president, spoke briefly to the delegates with suggestions on how to report effectively to their auxiliaries what had been discussed at the meetings and ideas they had gleaned.

Guest speakers presented various aspects of hospital service. Mr. L. Hughes, engaged by the Auxiliary to Shaughnessy Veterans' Hospital to act as host to patients there, told of the many varied services he performed, shopping, writing letters — even picking up personal belongings left behind in some pensioner's room. Mrs. E. Pringle, assistant secretary to the B.C.H.A., spoke on the timely subject, "Aspects of Care for the Chronically Ill". Mr. F. Wilson, a public relations director in industry, presented the public relations picture as it applies to hospitals. Jessie Fraser, assistant editor of *Canadian Hospital*, urged that items of news concerning activities in B.C. be sent in to their own publicity officer who would then make them available to the National magazine.

Delegates were taken on tours of local hospitals and of the Western Rehabilitation Centre in Vancouver.

This year, instead of hearing an individual report from each delegate to a general meeting, three groups were set up according to the size of hospital represented — up to 50 beds, 50 to 125 beds, and over 125 beds. Individual reports were then heard in each group, together with discussion and questions; then a summary of the highlights in each group was reported back to the general session, with time after each summary for questions. It was felt that this was a great improvement on the former system. It was recommended that the groups be made even smaller in future to allow for more discussion in each.

At the Round Table session, the working of a Council of Auxiliaries in a rural area where each served one hospital was explained by the delegate from that area. She described how council meetings are held every two months with representatives from individual auxiliaries who may then co-ordinate their work, and plan their time-table of activities. Individual auxiliaries function as units complete with all officers, yet working within the framework of the Council. It is found to be very effective.

A Future Nurses' Club under the sponsorship of the local high school was explained by another delegate. The hospital encourages girls in the club by giving them instruction and some Saturday duties at the hospital. It is felt that girls are encouraged, if suited, to enter the nursing profession by this groundwork.

Also at the Round Table, a discussion of what was desired in convention programs brought out some new ideas and served as a directive for future program committees.

At the annual meeting, reports were heard from provincial officers. The president reported four affiliations during the year of new auxiliaries, and stressed the outstanding interest of groups in the farthest corners of this province, who attend in spite of great distances and difficulties of transportation.

Social interludes included a banquet and dance at which the auxiliary delegates joined with those from the Western Institute. Tea followed the tour and closing luncheon at which the guest speaker was the Very Rev. N. R. Burke, Dean of Christ Church Cathedral, Vancouver.

Officers for 1956-57 are:

President—Mrs. F. E. Atkinson, Summerland

Immediate past pres.—Mrs. Forbes Perkins, Vancouver

First vice-pres.—Mrs. C. S. Stigings, Vancouver

Second vice-pres.—Mrs. A. J. Tripp, Vancouver

Secretary—Mrs. R. G. Byron-Johnson, Vernon

Treasurer—Mrs. L. F. Knight, Prince George

Publicity Officer—Mrs. A. Sturrock, North Burnaby

—Reported by Laura Tripp

• • • •

Worthy Record of Achievements

The eighth annual report of the Princess Elizabeth Hospital Guild of the Princess Elizabeth Hospital, Winnipeg, Man., emphasizes the bringing of personal cheer and comfort to the patients rather than monetary help. They have: systematic personal visiting of every patient every Monday; service carts and library carts; letters written and permanents given; Christmas, Easter and birthday cards mailed to all patients; all wards decorated and a Christmas concert party taken through the wards. This year the Guild allocated $500 for education and rehab-

(Continued on page 72)

Delegates to the Auxiliaries Division of the B.C.H.A. on the steps of Brock Hall

ilitation purposes; sent the Fort Garry Kiwanis $1,041 to be spent toward the building of a hydrotherapy pool, and set aside $2,000 to be used for furnishings for the pool. Donations to the hospital included: a homemade afghan for each patient, two typewriters, three wheel chairs, electric razors, electric clippers. They realized nearly $1,700 at the annual Spring Basket Tea.

• • • •

Prince Edward Island Hospital

The Prince Edward Island Hospital (Charlottetown, P.E.I.) campaign to raise $250,000 is being well supported by the Senior and Junior Ladies' Aid of the hospital. Together they have pledged themselves to underwrite $15,000 of the cost of the modernization and construction program, the senior group pledging $5,000 and the junior group, $10,000. Two members of the Junior Aid make a tour of the hospital every afternoon with books, confectionary and other items for the patients.

• • • •

Toyland

At a recent meeting of the Montreal Children's Hospital Women's Auxiliary, Montreal, P.Q., it was announced that a children's gift shop will be opened in October. This is a new venture for the hospital and a committee is presently engaged in planning for the shop which will deal exclusively in the sale of children's playthings and needs.

• • • •

Gift Cart for Espanola Hospital

The Ladies Auxiliary to the Espanola General Hospital, Espanola, Ont., plan to place a gift cart in the hospital this year. Articles such as postage stamps, stationery, post cards, new baby clothes, cosmetics and soaps, crayons and colouring books, as well as cash donations will be welcomed.

• • • •

South-Western Manitoba Group Organized

At the first meeting of the South-Western Area of Hospital Auxiliaries of Manitoba, held in Deloraine, Mrs. G. A. Davis, provincial president of Manitoba Hospital Auxiliaries, was guest speaker. Delegates took a tour through the new Deloraine hospital.

• • • •

New Brunswick Joint Meeting

Women's Hospital Aids in New Brunswick raised $28,070 in 1955 and spent $23,403 in the same period for the purchase of linen, equipment and other supplies for New Brunswick hospitals. This was announced at the first business session of the Maritime Hospital Aids Association held in conjunction with the 14th annual convention of the Maritime Hospital Association, at St. Andrews, N.B.

• • • •

Will Celebrate 50th Anniversary

Proceeds from a rummage sale and the sale of tags held recently by the Ladies' Auxiliary to the Wingham General Hospital, Wingham, Ont., reached a total of $1,254. This will be used to purchase bedding and draperies for the hospital and the nurses' residence as well as nursery supplies, et cetera. This group, organized in 1906, plans a suitable celebration in October to commemorate its 50th anniversary.

• • • •

Tag Day

The Women's Auxiliary to the Brome - Missisquoi Perkins Hospital Sweetsburg, P.Q., collected $1,501 from a tag day which was held recently in the Brome-Missisquoi counties and the town of Waterloo, P.Q., a fine reward for the retiring efforts of the convenors and canvassers.

• • • •

Pledge $15,000

The Women's Hospital Aid presented a cheque recently to the Brandon General Hospital, Brandon, Man., for $15,000 to the hospital's building fund. The 60 ladies of the aid provide all necessary linen supplies for the institution, operate the hospital snack bar, serving both patients and staff, hold rummage sales and teas, with proceeds directed toward some needy phase of hospital operation, and have contributed toward the cost of beds.

• • • •

Assist in Improvements

The new out-patients' department at the Salvation Army Grace Hospital, Ottawa, Ont., was furnished by the Women's Auxiliary of the hospital at a cost of $1,550. They also raised funds to purchase a gas machine, costing $1,082 and furnished the prenatal clinic.

• • • •

Give Hospital $600 Grant

The White Rock District Hospital Auxiliary at White Rock, B.C., have given $600 to that hospital. Their tag day added $248 to the treasury which made a total of $640 on hand as of June 1st. Plans are already being made for this year's Christmas pantomime.

• • • •

Another Donation to Queensway Hospital

A cheque for $5,000 was presented to the Queensway Hospital Board recently on behalf of the Queensway Hospital Women's Auxiliary, Toronto, Ont. This brings to $6,500 the amount paid to the board by the auxiliary which has promised to reimburse the board for $16,000 worth of material bought by the board, and which the women of the auxiliary are turning into sheets, doctors' gowns, caps, and other necessary items for the hospital.

• • • •

Glassed-in Sun Deck

Planned to be completed soon is one of the largest projects ever undertaken by Calgary Children's Hospital Aid Society — the provision of a glassed-in sun deck for the Alberta Red Cross Crippled Children's Hospital, at Calgary, Alta. Projects carried on by this group this year include their very successful Easter seal campaign, an Easter tea, and the sale of programs at football matches, which together with smaller items made a net profit of $6,315.

• • • •

Draw on Treasure Chest

The objective of the Women's Auxiliary to Campbell River and District General Hospital, Campbell River, B.C., for last year was the purchase of an electrically heated tray carrier. To help raise the necessary funds they held a draw on a completely filled cedar chest, and other articles. It went over so well that they bought two tray carriers. Their members also helped with the blood bank and the tuberculosis chest x-ray.

• • • •

Discards Mean Money For New Hospital

An "Opportunity Shop" is run by the Women's Hospital Auxiliary to Groves Memorial Hospital at Fergus, Ont. All stock is donated and sold at reasonable prices. The total for last year, including clothing and the auction sale of fittings of the old hospital, was $1,736. This money is used to buy equipment for the new hospital there.

• • • •

Saskatchewan Hospital Auxiliaries

Special guests at the Saskatchewan Hospital Auxiliaries Association convention (District No. 2) held recently at Biggar, Sask., included Dr. A. L. Swanson, Superintendent of the University Hospital, Saskatoon, and Mrs. Swanson. As guest speaker, Dr. Swanson, chose as his topic "The Purpose of Hospital Auxiliaries", and afterwards showed slides of the University Hospital.

• • • •

Help Cerebral Palsy Clinic

The W.A. to the Cerebral Palsy Clinic of Royal Jubilee Hospital, Victoria, B.C., is extremely proud of the work done by its corps of volunteer workers. More than 30 women give half a day a week to this work.

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Work Conference

(Continued from page 53)

no pharmacist, et cetera. As doctors delegate more duties to nurses, it becomes necessary for nurses in turn to delegate to others. Such personnel as ward clerks, ward aides, and others, where employed, assist in relieving nurses of non-nursing duties.

It was also found that in many hospitals leave for patients, unless controlled, constitutes a troublesome problem — as are visiting hours in some hospitals.

Session II

Following a lecture-discussion upon the principles and methods used in preparation of the budget of the department of nursing, individuals and groups worked upon problems related to the computation of staffing requirements for wards and hospitals.

Session III

Groups discussed problems of mutual interest in regard to the utilization by the department of nursing of personnel and other available resources. Their reports were presented and a general discussion period followed, during which suggestions were made regarding solutions to problems raised during the work conference. The wish was expressed that hospital administrators and trustees might have been present, since the solution of so many of the nursing service problems necessitates the combined efforts of the administrative officers of the hospital and its nursing administration. This is particularly true since, in the words of Dr. Louis Block:*

> "Nursing service is the largest of all hospital departments; it is influenced by and influences all other departments of the hospital. The operation of any one of the hospital departments is in some degree reflected in the effectiveness of each of the other departments. In practically all instances, hospital services are relayed or transferred to their recipient, the patient, through the nursing service. As such, the nursing department becomes a crossroads where all departmental administrative practices intersect or converge."

Recommendations for Future Action

Although the limited time available did not allow full discussion of problems during the work conference, participants reached certain conclusions—chiefly concerning personnel—and indicated some recommendations for future action.

It was felt that personnel policies should be drafted in consultation with representatives of the nursing personnel concerned (whether professional or non-professional), and be discussed before final acceptance in a joint committee composed of representatives of the nursing personnel and the administrative officers of the hospital. Prospective employees might be made acquainted, before employment, with the personnel policies of the hospital, the minimum tenure for the position defined, and promotional opportunities and salary increments which might be expected. In the smaller hospital, particularly, the community might encourage stability of tenure by helping members of the nursing staff feel at home.

Programs of staff education should be developed, if possible, under the leadership of one person assigned this

(Concluded on page 76)

Block, Louis, Dr. P. H., "Control means more than Low Costs", The Modern Hospital, February, 1956. (Reprint available)

C. H. A. Library is for your use

THE PURPOSE of the Canadian Hospital Association library is to be of assistance to the personnel in Canadian hospitals. In addition to a fine collection of books, manuals, and pamphlets, the library maintains files of articles clipped from current journals on subjects pertaining to the various aspects of the hospital field. Packages are made up in accordance with specific requests. All material is available for a three-week loan period. There is no charge for this service. These packages are authorized as third-class matter and may be returned to the librarian at the rate of 2¢ for the first two ozs. or fraction thereof and 1¢ for each additional two ozs. or fraction thereof, or at the parcel post rate, at the option of the sender.

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Work Conference

(Continued from page 74)

responsibility in the department of nursing. This would include provision for careful orientation of new staff members, particularly in rural hospitals, and special in-service preparation for areas of nursing service with which the new staff member is unfamiliar, or refresher courses for nurses returning to active service after some absence from it.

Among the more detailed suggestions that followed, regarding personnel, it was mentioned that nursing personnel engaged in hospitals should be encouraged to seek further preparation, *e.g.* at university, and be granted leave of absence, in order to improve the quality of the nursing service. Also, the utilization of married nurses would assist in stabilizing the nursing service — consideration being given, where necessary, to making special adjustments in conditions of employment to meet individual circumstances. In the absence of provision of holiday relief staff, and existence of a consequent shortage of nursing personnel during a holiday season, wards should be closed where practicable, to ensure the most effective utilization of available staff to give safe nursing care. In order to reduce absenteeism in the department of nursing, the health of employees in the hospitals could be supervised by the health service, medical examinations arranged, and records kept of illnesses.

The need for qualified instructors to teach and supervise students becomes clear when planning to provide affiliation for student nurses in smaller hospitals as a means of preparing them more effectively for later professional service in such institutions and their communities. Courses should be planned in nursing service administration: (a) correspondence and summer school, and (b) regular university courses. Nursing service administrators might also be invited to assist in the establishment of budgetary policies for the hospital.

Finally, it was felt during discussion that overcrowding in hospitals should be controlled through well enforced admission policies; also, that courses should be established for orderlies, similiar to those for certified nursing aides or practical nurses. In an effort to promote better patient care and more effective utilization of available resources for giving care, it was suggested that nursing service research be encouraged in individual hospitals, and that consultant services be made available to hospitals to guide them in regard to methodology found to be useful and practical in conducting such studies. It was further mentioned that to assist the department of nursing in computing staffing requirements for wards and departments for a budget period, a statement of the number of patient days anticipated for each such area monthly, for the period of the budget, should be made available by the business manager or appropriate official.

Conclusion

All nurses enrolled in the work conference expressed sincere appreciation for the opportunity to discuss nursing service problems of the present day. Group leaders for the conference were as follows: Miss Gladys Armson, Instructor, Miss Roberta Cunningham, Instructor and Head Nurse, Sister Anne of the Sacred Heart, Supervisor, and Mrs. Helen Stewart, Associate Director of Nursing Service, — all of St. Paul's Hospital, Vancouver; Miss Norma Wylie, Supervisor, Vancouver General Hospital; Miss Esther Paulson, Director of Nursing, Pearson Tuberculosis Hospital, Vancouver, and Nursing Consultant for the Division of Tuberculosis Control in British Columbia;

Work Conference

(Concluded from page 76)

Miss Wilma Wood, Director of Nursing, Willow Chest Centre, Vancouver; Miss Joan Gore, Instructor, and Miss Esther Janzow, Assistant Director of Nursing Service, — both of the Royal Columbian Hospital, New Westminster; Mrs. Myrtle Saxton, Matron and Business Manager, Tofino General Hospital, B.C.; and Miss Doris Watson, Assistant Director of Nursing, Royal Alexandra Hospital, Edmonton. In charge of organization of group work and general arrangements was Miss Lorna Horwood, Assistant Professor, University of British Columbia School of Nursing; while Miss Elizabeth McCann, Assistant Professor also in the same faculty, was Chairman of the Recording and Resolutions Committee, assisted by Sister Anne of the Sacred Heart and Miss Wilma Wood.

People

(Concluded from page 20)

assistant secretary (public relations) to the Ontario Medical Association. Mr. Ferchat had previously held the post of assistant director of public relations to the Ontario Hospital Association for the past eight years.

C.M.A. Executive

Dr. M. Morley Young of Lamont, Alta., was named president-elect of the Canadian Medical Association, a position that he will take over at the annual meeting in Edmonton next year —succeeding this year's president, Dr. Renaud Lemieux of Quebec. Dr. Norman H. Gosse was elected chairman of the general council, while Dr. E. S. Mills of Montreal becomes honorary treasurer.

* * *

International Representative

Dr. Jean F. Webb, child and maternal health consultant in the Department of National Health and Welfare, has attended the Eighth International Congress of Paediatrics in Copenhagen, Denmark from July 21 to 27th. Dr. Webb will later carry out an official observation tour of the United Kingdom and Scandinavia to study maternal and child health services for handicapped children.

• It was announced recently that Grace Motta, superintendent of nurses at the Moose Jaw Union Hospital, Moose Jaw, Sask. for the past 13 years, has resigned, to the regret of the local community.

Appointment of New Matron

Dorothy Hoult, who was earlier in charge of a Red Cross Outpost Hospital on Cape Breton Island for two years, has been appointed matron of the Victorian Hospital of Kaslo, Kaslo, B.C., replacing Mrs. C. R. Higgens, who returns to Nelson, B.C.

• Elizabeth (Lloyd) Quinn Corbett, was working as a nursing sister at the Riverdale Isolation Hospital, Toronto, Ont., up to the day before her death. Mrs. Corbett received her nursing training at St. Joseph's Hospital, Port Arthur, Ont., and served overseas with the Canadian Army in World War I. During World War II, she received French decorations for her work in Canada for the Free French Movement.

• The death has been announced of a former missionary, Dr. Edward Corry Wilford. Dr. Wilford spent 40 years with the West China Mission of the United Church of Canada, where he had served as superintendent and surgeon in several hospitals and as a professor of surgery at West China Union University. He graduated in medicine from the University of Toronto in 1908.

(Concluded from page 34)

These programs should be conducted in a rehabilitation centre with in-patient beds and all the facilities for continued treatment and retraining of both in-patients and ambulatory patients. The staff must be specially trained. The centre should be built on a regional basis or, if the city is large enough, on a city basis. Rehabilitation centres have already been established in certain localities, but their number is woefully small in comparison with the needs of the nation. There must be the greatest co-operation between the acute general hospital and the centre, with representatives from the latter being called to the hospital at the first possible opportunity to help plan the rehabilitation program.

In one study in the United States it was reported that 140 disabled men and women were receiving $92,400 a year in public welfare. The same 140, after rehabilitation employment, were earning at an annual rate of $156,240. Further, it has been estimated by the United States government that for every dollar spent on rehabilitation the Treasury has collected $10.00 on income tax from rehabilitated workers. In West Virginia during 1951 the disabled members of 376 families were receiving annually about $225,000 in assistance payments. It cost less than this amount to rehabilitate them. Now they are not only off the public rolls but they are earning about $500,000 a year. (I have cited these three groups of statistics from an address by Dr. F. H. Krusen of the Mayo Clinic given in Montreal last January.) It is reasonable to suppose that if similar studies were carried out in Canada the results would not be very different.

Financing of Hospital Care

The Federal Government announced last October that "when a majority of the provincial governments, representing a majority of the people of Canada, are ready to put into effect programs to provide hospital care as a measure of health insurance, the federal government will recommend to parliament legislation to provide financial support and technical assistance to the provinces for such programs." In January last, the Federal Government announced further that the "program in which we would share would provide standard ward care . . . and laboratory, radiological and other diagnostic services for patients outside of hospitals as well as in them," and "It will mean that on the whole the federal treasury would bear about one half of the net shareable operating costs of such programs of hospital insurance."

Some provinces—but not the required majority—have accepted the proposal of the Federal Government. Exhaustive studies are necessary by each province before it can give a definite answer to Ottawa's proposal. It is not our place to anticipate those decisions. I would urge, however, that in each province the officers of the hospital associations offer their fullest co-operation to the provincial government in its studies of hospital insurance, and—more important—see that such an offer is accepted. I hope that the provincial government officials would welcome the advice and technical assistance which we in the hospital field are able and ready to give.

Conclusion

These are a few thoughts on the future. You will note that they are just as applicable under one system of financing of hospital care as another. They are by no means the only points of importance in our day-to-day life but I feel they are at the top of the list. They deserve the best attention we can give them.●

Special General Meeting of the B.C. Hospital's Association

While the constitution of the British Columbia Hospitals' Association calls for an annual convention to be held in the Fall of the year, it has become customary, when the Western Canada Institute is held in that province, to hold a special general meeting following the week of study. This took place on Saturday, June 16th.

Among the resolutions adopted by the Association were the following:

WHEREAS existing facilities for chronic patients and for their maintenance are inadequate;

THEREFORE BE IT RESOLVED that the provincial government be asked to enact legislation which will authorize the appropriate government agency or agencies to effect the provision of adequate chronic care without delay when the need appears, and

FURTHER that the government be asked to make provision for reimbursing hospitals for the expense of caring for chronic patients until suitable alternative care can be found for such patients by responsible government agencies.

RESOLVED that B.C.H.I.S. be asked to let hospitals know by May 1st each year whether their budgets are confirmed or amended.

RESOLVED that the British Columbia Hospitals' Association recommend that all member-hospitals, who wish to circularize all or any particular section of our member-hospitals for specific information on any subject, first of all submit their questionnaire to the Association secretary in order that he may supply the information from his files when available, and thus prevent unnecessary duplication of effort among member-hospitals.

WHEREAS B.C.H.I.S. Circular 56-4 gives some measure of relief to hospitals from the former policy of "frozen" budgets;

AND WHEREAS this relief, whilst welcome, is quite inadequate to enable hospitals to meet their obligations without running into debt;

THEREFORE BE IT RESOLVED that the Executive be requested to interview the Minister of Health and Welfare again and again, presenting to him the problems of the hospitals, urging upon him to arrange for some further measure of financial relief to all hospitals suffering deficits in their operations.

At this meeting, the president, J. A. Abrahamson of Revelstoke, reviewed the work of the Association during the past year. In speaking of visits to regional meetings throughout the province, he gave special credit to Mrs. G. C. Chandler, chairman of the trustee section, who had made several journeys to interior regions.

Mr. Abrahamson was unanimously re-elected president for the year 1956-57, as were other members of the executive. These are: immediate past president, Harvey E. Taylor, Port Alberni; first vice-president, L. F. C. Kirby, New Westminster; second vice-president, H. R. Slade, Powell River. Percy Ward continues as secretary-treasurer of the Associaton, with office at 129 Osborne Rd. East, North Vancouver.

"The tuberculosis problem is with us perhaps to an even greater extent than formerly, because we tend to discharge the patient sooner as chemotherapy controls the contagious aspects more quickly," Dr. Harry Shubin of Philadelphia declared. He pointed out that many patients fail to realise the urgent necessity of a continued close medical supervision and rehabilitation for a long time after leaving the sanatorium. — *World Wide Medical News Service.*

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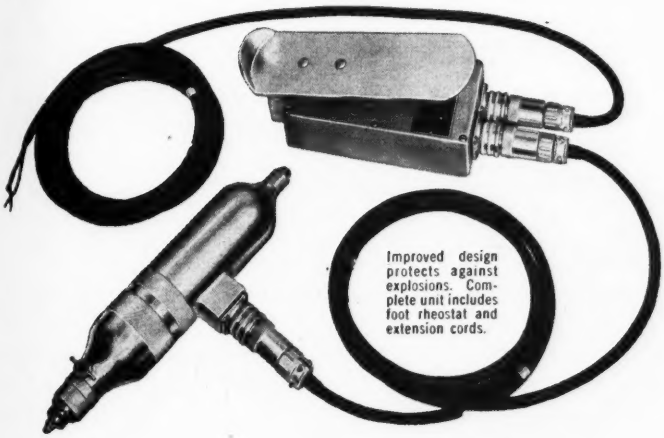

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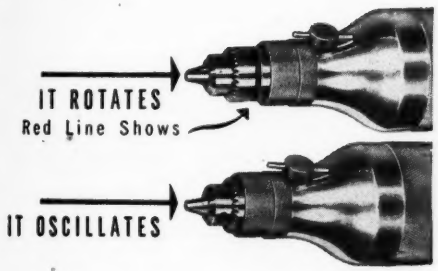

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Twenty Years Ago

(*The Canadian Hospital*, Aug., 1936)

Turning over the pages of our hospital periodicals during recent months, we note that many communities are considering building programs in the form of new buildings or additions, and so we make what we hope is a timely suggestion to administrators, not to overlook the value of engaging some reputable hospital consultant to act as advisor to them. This suggestion is made only because innumerable hospitals in the past who have been guided soley by local opinions find within a short time that the buildings do not adequately meet the needs for which they were intended, or that the operating cost is out of all proportion to that anticipated.

Whether a hospital is a large one with its own dispensary and dispensing staff, or smaller in size with all of its medicinal requirements supplied from outside sources, the adoption of a definite collection of formulae to serve as an official Formulary or Pharmacopoeia offers decided advantages. While this has always been true, and larger institutions have long since followed this practice, there was never a time when emphasis on recognized standard drugs and preparations was so necessary as at present. Even the smallest hospital cannot afford to overlook the economies and the improved results which follow the rationalization of drug therapy, and the adoption of a Pharmacopoeia is an important step in this direction.

In her attitude towards the patient the nurse must often submerge personal feeling. If she could always keep in mind that in her work she is never dealing with physically and mentally normal people, it would be much easier for her to maintain a proper attitude towards her patient . . . Kindness must be unfailing . . . She must realize that the patient is suffering . . . and that many procedures are disagreeable, but that kindness exercised in carrying them out will make them less unpleasant. Related to kindness is consideration for the weaknesses and foibles of others. The patient is sick, or he would not be in the hospital. He has acquired more or less fixed habits, perhaps real faults, which must be regarded if irritation is to be avoided . . . Perhaps the virtue which will be most often taxed is forbearance . . . The friends of the patient are often a greater source of trouble to the nurse than the patient himself. Visitors resolve themselves into two classes: near and dear friends, and the casual visitor. Ministers of the church are usually considered in the same category as intimate friends.

Is it ethical for a hospital to give an article to the press when a new department is opened or new equipment purchased? It is both ethical and desirable for a hospital when it adds to its facilities for the treatment of the patient to allow a report of such progress to be published in the press, providing that the spirit of such a report is not designed to bring aggrandizement at the expense of other hospitals in the community. Even if you are certain that your achievement is original . . . in your locality . . . be careful not to emphasize it. Also, get the co-operation of the reporter in assuring that he will refrain from using spectacular phraseology which may have news value, but is not dignified.

To commemorate the heroic efforts of the Nova Scotia miners and to express their personal appreciation of the rescue of Dr. D. E. Robertson, their Chief Surgeon, and Mr. Alfred Scadding from the Moose River Mine, the

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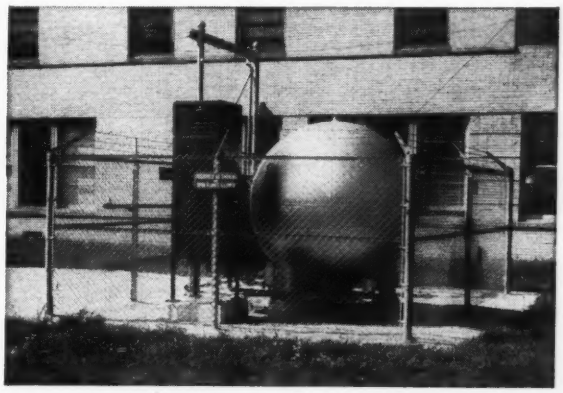

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(Concluded from page 84)

officers, staff, and employees of the Hospital for Sick Children in Toronto have raised a fund for the endowment of a cot to be placed in the Children's Hospital at Halifax. This cot will be devoted to the care of children of Nova Scotia miners.

While it is relatively easy for the editorial board of the *Canadian Hospital* to get articles from authoritative sources on almost any subject relative to hospital work, the very fact that the field is so large makes it difficult to select the subjects that are really wanted by administrators. However, the problem can be solved if our readers will only take the necessary five minutes to fire their questions and problems at us, and state frankly what they really want to read about. "Fan Mail" indicates whether the results of our labours are falling upon stony or fertile ground. Don't be apathetic—write your Editor — be as critical as you like!

The suggestion is often advanced that hospitals should be paid for the training of nurses. The cost of providing training would appear to exceed considerably the amount of nursing service which the student nurses are able to give to hospitals. On the other hand, it is doubtful if hospitals receiving such grants from the state would feel justified in continuing to pay merely nominal salaries to probationers. — *From a Report of the Scottish Departmental Committee on the Training of Nurses.*

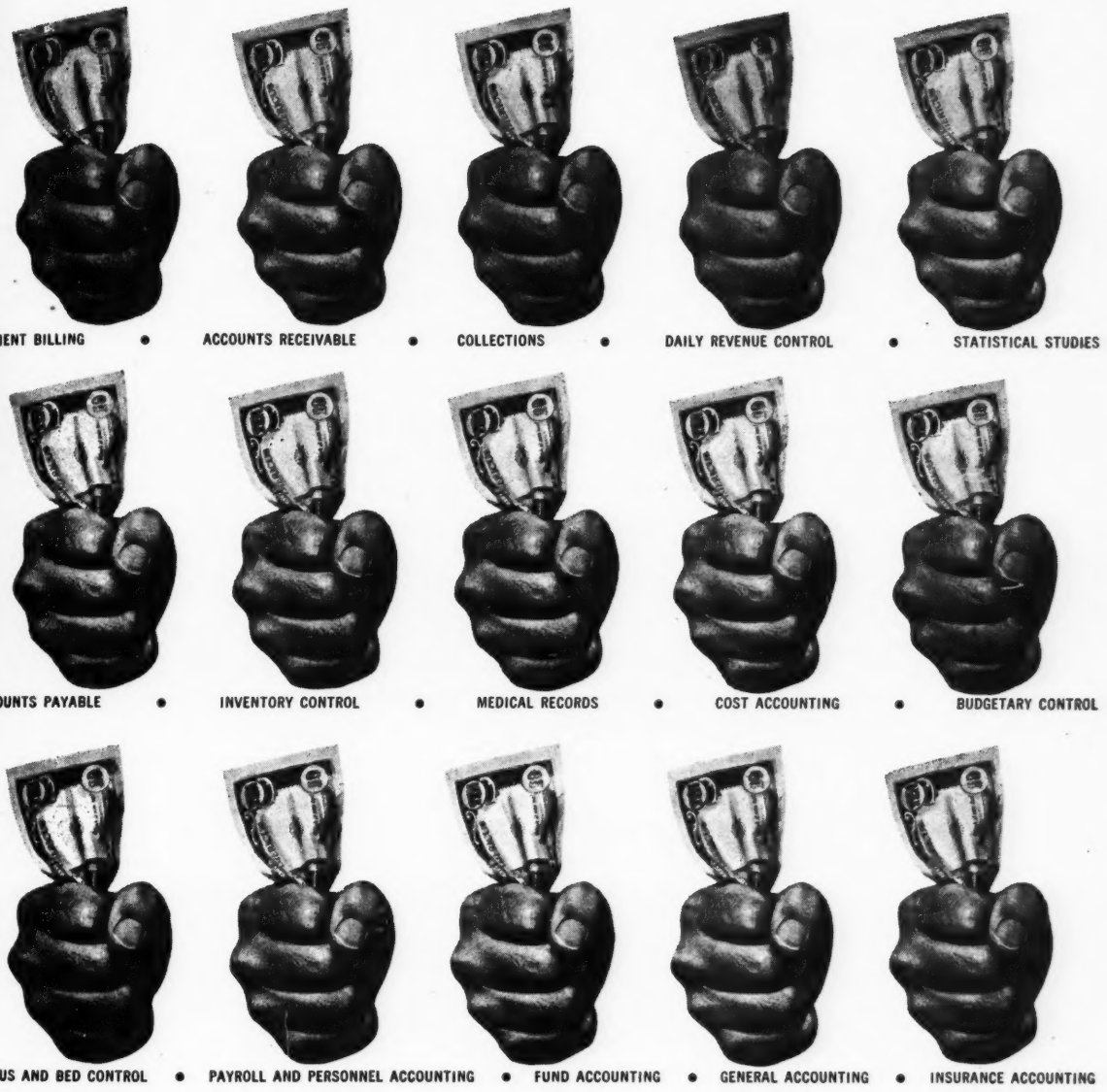
Cancer Foundation Gives Grants Worth $62,727

Seventeen grants for clinical cancer research totalling $62,727 and a grant for basic cancer research of $1,068 were announced recently. Three of the grants are for new projects being undertaken in Toronto, and 14 for the continuation of projects started in previous years. These grants bring the total of awards by the Ontario Cancer Foundation for cancer research to $790,000 since the foundation was established in 1943.

High Humidity Ward

During the past seven years the Children's Hospital in Vancouver, B.C., has been using a tiled humidity ward with automatic spray mechanism providing 100% humidified air for kiddies suffering from respiratory disorders. So successful has this mode of care been, as against individual box-like humidifying units, that in over 600 cases it has been necessary to perform only one tracheotomy. Last year 283 patients suffering from various types of pneumonia, asthma, bronchitis and post-operative stridor were treated there — 83 more than the previous year. The anonymous donor who originally made the high humidity room possible has come forward again with the addition of a "drying out room" re-modelled from an adjacent ward. Thus the hospital now has a complete respiratory unit.

—*B.C. Children's Hospital*



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Coming Conventions

Aug. 28-29—Maritime Conference of the Catholic Hospital Association of Canada, Notre Dame D'Acadie Convent, Moncton, N.B.

Aug. 29-Sept. 1—Canadian Society of Radiological Technicians, Empress Hotel, Victoria, B.C.

Sept. 12-13—Catholic Hospital Conference of Alberta.

Sept. 15-19—American College of Hospital Administrators Annual Meeting, Palmer House, Chicago.

Sept. 17-20—American Hospital Association Convention, Chicago, Ill.

Sept. 17-20—American Association of Hospital Consultants, Palmer House, Chicago, Ill.

Oct. 1-5—International Congress on Medical Records, Shoreham Hotel, Washington, D.C.

Oct. 10-12—Convention, Canadian Association of Medical Record Librarians, Vancouver, B.C.

Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 22-23—Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 21-23—Women's Hospital Auxiliaries of Ontario, Royal York Hotel, Toronto, Ont.

Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 25-26—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Oct. 27-29—Canadian Association of Occupational Therapy, Montreal.

Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.

Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

Physiotherapy in England

Two physiotherapists from London attended the World Confederation for Physical Therapy held recently in New York City. They reported that physiotherapy is a flourishing profession in England, where there are 20,000 physiotherapists for a population of approximately 50,000,000, as compared with 800 in Canada out of 15,000,000, and 5,000 in the United States for 180,000,000. The nucleus of teachers here came from England, but now the time has come when Canada is sending teachers to England, they said. There is a tremendous interest on the part of English students to come to Canada after graduation.

In England they stress specific treatment, but on this continent, both in the United States and in Canada, there is a tremendous emphasis on educating the patient so that he can become self-dependent. An interesting development on this continent is the combining of physical and occupational therapy in training courses, something which has not yet been done in England. Also interesting to the two visitors was the system of visiting physiotherapists used so effectively by the Canadian Arthritis and Rheumatism Society in the western provinces.

Bed Needs

(Continued from page 62)

80 — even up to 100 per cent. In such hospitals there is justification for new construction to increase capacity. Where the measured capacity exceeds the calculated *bed need*, it is evident that the hospital is over-sized (due perhaps to loss of local population, over-zealous initial construction, or other factors) and certain beds or wings should be closed down temporarily. Still other adjustments are necessary to take account of very new hospitals in which the public's choice of hospital accommodation has not yet had a chance to express itself; or of certain hospitals where departmentalization and building lay-out may dictate a desirable occupancy of 75 or even 70 per cent, rather than 80 per cent; or of very small hospitals in which the logistics and economics of management yield a minimum recommended occupancy of 8 patients, even though the calculated figure might be less than this.

Conclusions

This approach to estimation of the *bed need* of each hospital in Saskatchewan has been applied during the past year and has proved useful in several ways. It has assisted in objective appraisal of hospital budgets, on the basis of which payments for patient care are made under the Hospital Services Plan. It has enabled the Department of Public Health to answer rationally the frequent demands made by individual hospitals for expanded bed allowances. It enables the department to evaluate the requests of hospitals for permission to construct new wings which would enlarge measured capacities — so that future bed needs can be equitably met without over-building in one locality and under-building in another.

The obvious limitation of this formula is that it will not provide guidance directly on the *bed need* in a totally new community where no hospital has previously existed. For this, resort must still be taken to a static formula (such as 4.5 beds per 1,000 persons in the nearby trade area) as an initial basis, with provision allowed for future changes. Analysis of Saskatchewan experience after eight years of universal hospital insurance suggests that the use of distant district and regional hospitals is proportionately greater, in relation to the use of local community hospitals, than had been earlier thought. This should affect future planning of new hospitals.

The changing pattern of urban settlement in a young province like Saskatchewan creates problems in hospital planning more serious than those in provinces where the configuration of cities and towns is relatively crystallized. In this agricultural country, there are hundreds of small, scattered villages whose futures are uncertain; for as transportation improves and farm units become larger, the population inevitably is becoming concentrated in a smaller number of larger towns. Residents of a declining village, to help resist this trend, often cling to their small hospital, using it for services which could be better given at a larger district hospital nearby. Nevertheless, the increasing choice of the people as a whole for the larger district or regional hospitals is being shown in the data. Study of the year-by-year trends in the size of the apportioned population of each hospital gives guidance on the use of public funds for the expansion of one hospital as compared with another. Of course, the supply of physicians and nurses, the roads, economic resources, et cetera, must also be considered, along with the findings from the formula. Taken altogether, these factors help to provide guidance on over-all hospital planning. It is

(Concluded on page 92)

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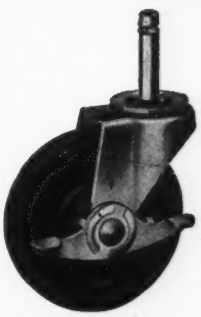

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Bed Needs

(Concluded from page 90)

hoped to elaborate these points later.

The approach to hospitalization presented in this paper attempts to take account, with reasonable flexibility, of the wishes and choices of the people in a changing world of science. The results in estimation of *bed need* in particular localities and particular hospitals will change from year to year, in accordance with shifts in populations, personal preferences, transportation facilities, and evolving patterns of general and specialized medical practice. Yet flexibility is limited by the influence of averages, so that a fund of money for hospital care contributed by all the people can be equitably spent in fair proportion to their respective needs.

References

1. Reed, Louis J., and Hollingsworth, Helen, *How Many General Hospital Beds Are Needed? A Reappraisal of Bed Needs in Relation to Population.* U.S. Government Printing Office, Washington. (Public Health Services Publication No. 309), 1953.
2. Health Survey Committee, *Saskatchewan Health Survey Report,* II, *Hospital Survey and Master Plan,* Regina, 1951, pp. 44-45.
3. Department of Public Health, *Annual Report of the Saskatchewan Hospital Services Plan* 1954, Regina, 1955.
4. Roth, F. B., Myers, G. W., Mott, F. D., and Rosenfeld, L., "The Saskatchewan Experience in Paying for Hospital Care," *American Journal of Public Health,* 43:752-756, June, 1953.
5. Roth, F. B., Acker, M. S., Roemer, M. I., and Myers, G. W., "Some Factors Influencing Hospital Utilization in Saskatchewan", *Canadian Journal of Public Health,* August, 1955.
6. Myers, G. W., "Hospitalization among Residents of Urban and Rural Communities," *Canadian Journal of Public Health,* 44:43-50, February, 1953.

Medical Plan Nearly Doubled During Year

Last year showed the greatest growth of any year in the history of Trans-Canada Medical Plans, a group of prepaid medical care plans sponsored by the medical profession. A total of 2,403,351 persons was covered by the medical plans at the end of last year — a net increase of more than 300,000 persons, almost double the previous year's increase. These facts were revealed in a recent report of the economic committee of the Canadian Medical Association. As its share in financing T.C.M.P. the C.M.A. has voted to contribute $4,000 for this year. It will also set up a department of economic research for interpretation of medical trend statistics, and related factors, to be operated jointly with T.C.M.P.

People and Supplies

(Continued from page 56)

facilitate issuing medical and surgical supplies to the nurses' stations and to simplify the inventory entries for these.

The approved requisition forms from the nursing units should reach the stores by Tuesday morning. The stores secretary then transcribes the requisitions to the summary slips, item by item.

The slips are taken by the clerks (Wednesday morning) who fill the requisitions and are then passed to the purchasing secretary who enters the totals on the inventory cards.

While entering the quantities issued, the balances have to be checked against the minima. If the quantity on stock reached or went below the minimum level, the item is listed on the "Routine Purchase Requisition Form", along with the code number, quantity to be ordered, name of most recent supplier and the latest price. This form has a number of blank columns to be used by the purchasing agent when obtaining quotations.

When the item is listed on the purchase requisition form, a coloured tab is attached to the inventory card (to be removed when the merchandise is received) in order to avoid duplicated orders.

The accounting office clerks, while entering the cost prices of the received goods from the invoice, audit the records by checking: (a) the quantities shown as received (against the invoice); (b) that quantities on hand do not exceed maxima; and that if minima are reached, orders are placed.

Unusually large issues are immediately apparent to anyone handling the records; but primary responsibility should rest with the storeskeeper to check on any request that looks unreasonable.

The purchasing agent should, at approximately six months' intervals, review all cards and investigate inactive as well as overactive records. Physical inventory should be taken once a year but spot checking (by the comptroller or his assistants) is carried on monthly.

Markers on the shelves or near the storage space assigned to each item will show the minimum and maximum levels. Thus, an alert stores clerk will notice discrepancies without actually taking inventory. (The clerks were instructed to report these immediatly).

Personnel

Before beginning any work we have to be certain that the men available can and will do the job. On observation, the receiving clerk and two stores clerks were found to be honest,

reliable workers; the senior clerk proved to be extremely alert and sensitive to needs of the stores division. The workload is seldom overtaxing but elimination of any individual would be difficult due to the poor physical set-up (two floors) and because one clerk spends most of his time delivering supplies in the building. If the receiving room is to be covered at all times during business hours, we need more than three people; the present three, with the secretary (who has to make occasional trips to the accounting and purchasing offices) are just sufficient.

The work of the secretary in the stores is much less important than her presence. Actually, the secretarial duties do not take more than one to two hours daily. (As her presence is needed, the secretary will stay but be re-classified to come under the jurisdiction of the comptroller, who will give her additional assignments.)

Constant supervision with this system of intensive control is not needed. Control is largely automatic through the audit of the records in the accounting office. To create and maintain the necessary personnel relations, the purchasing agent spends a few hours every week in the stores and obtains reports on unusual occurrences.

The purchasing agent has the additional responsibility of reviewing the system periodically. It was decided that his routine duties will include reviewing the inventory cards twice yearly to spot inactive items and studying the comparative consumption records (made very easy by the form shown above) that he may be able to recommend advantageous substitutions and to offer other constructive criticism to the "consumers". The first review should include establishment of average consumption figures and should be preceded by several physical inventories to test the accuracy.

The Beginning

Physical inventory was taken of all items before the inventory cards were prepared. The system was installed in three steps: all non-perishable food items were put on perpetual inventory first; housekeeping, paper and sundry products were added as a second, gradual step; several weeks later, when the system had proved feasible, we added medical and surgical supplies, the largest group.

Each step was tested before a new one was undertaken. Thus, after non-perishable food items were inventoried for a month, physical inventory was taken again and all errors traced to their origin. We found that our previous inventory was inaccurate because of confusion which arose through

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People and Supplies

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simultaneous house-cleaning, inventory taking, receiving, returning and issuing operations. Accordingly, we were more careful with the later steps, especially while counting stock quantities.

Only three discrepancies were traced to clerical errors, all of them due to lack of experience. The clerks were again called to a conference, to supplement their training, and their work was closely supervised for a period.

We are now confident that errors in the future are unlikely, and that only unimportant ones could escape detection, even without physical inventory.

The original attempts at maintaining the inventory cards were made on a typewriter-bookkeeping machine. It was found that manual operation is faster and we do not have to rely on one or two machine operators, who—together with the machine—are already overloaded.

The clerks were trained so that they can relieve one another.

Results

In summary, it may be stated that we have the beginning of a system worked out whereby the stores, accounting, and purchasing departments control each other, co-operating in an efficient manner, and provide additional information with no additional expense.

The review itself resulted in a general house-cleaning in the stores, our stock is reduced substantially, yet we have all we need. This reduction liberated storage space which permits better accessibility to the goods stored and more flexibility for purchasing. The new set-up should make it easy to keep the area clean and avoid storing too much or too little.

The participation of other departments resulted in mutual understanding, enhancing the spirit of co-operation in the hospital by friction-free interdepartmental relations. ●

"Geriatrics"

Geriatrics is a term which came into existence only around 1940, when it was introduced by a Viennese professor, Dr. Muller-Dehn. Geriatrics as an accepted medical specialty is even more of an infant, though Sir John Floyer published a systematic work on the subject as early as 1724. Apparently the subject was an untimely one in 1724, however, for the next work on care of the aged did not appear in medical literature until a century later.

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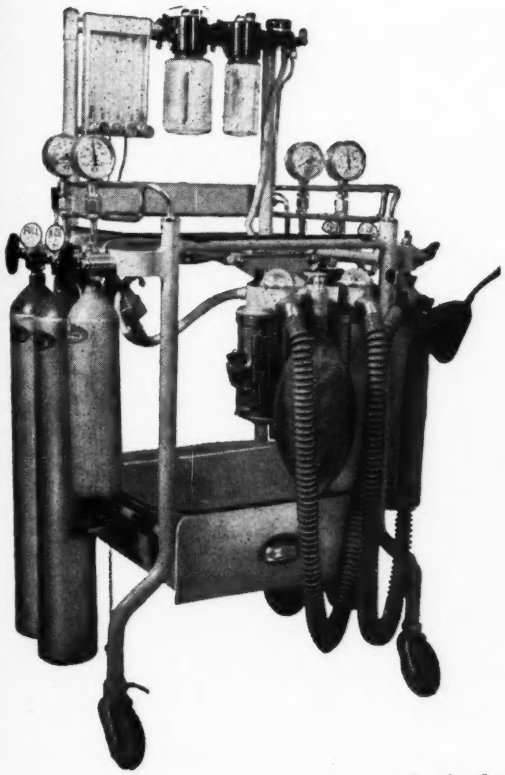

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(Concluded from page 64)

KINGSTON. The corner stone was laid at the official opening of the new wing of St. Mary's of the Lake Hospital by His Excellency Most Rev. Giovanni Panico, D.D., the Apostolic Delegate in Canada. The capacity of the hospital has been increased from 103 to 206, while the extension also includes expanded physiotherapy and occupational therapy departments together with a large auditorium.

LONDON. Victoria Hospital board of trustees have authorised the construction of smoke abating equipment, at a cost of $12,000, following complaints from local homeowners.

SMITHS FALLS. The Hon. George Doucett, M.L.A. for Lanark, and 13 other functionaries were present at a sod-turning ceremony for a 42-bed, $460,000 addition to the Smiths Falls Public Hospital, to be constructed this summer.

STOUFFVILLE. The 25-bed Brierbush Private Hospital has been taken over by Ernie Austin, who is also the owner of the Stouffville Nursing Home, which has 24 beds.

TORONTO. The recently opened Scarborough General Hospital was reported to have cost over $3,000,000, of which the Sisters of Misericorde have to date contributed more than one and a half million. This 188-bed hospital incorporates the most modern equipment and will be staffed by over 100 graduate nurses.

Quebec

HULL. Construction has progressed rapidly on the new 350-bed Hôpital du Sacré-Coeur, which will be ready for use by the fall of 1957.

MONTREAL. About 300 residents of Granby visited the site of the new St. Charles Boromée Hospital in 96 cars to put in a day of work organised by the Cercles Lacordaire and Jeanne d'Arc in co-operation with the Knights of Columbus of Granby. The group comprised 30 painters, 32 electricians, 10 plasterers, 21 bricklayers, 35 labourers, 100 workmen, and 25 women to cook dinner. Everyone gave his time free and brought his own tools.

QUEBEC. The Hôpital St-Luc Limitée was purchased recently by the Oblates missionaires de l'Immaculée whose organization possesses some 40 such institutions in Canada, including three in Quebec City, for the care of the sick.

New Brunswick

CAMPBELLTON. Work is proceeding on the $2,250,000 expansion plan for the Provincial Hospital. Block "A" is slated for completion by October 31, adding 152 beds to the hospital's present 225 capacity. Blocks "B" and "C", scheduled for completion by the end of 1957, will increase the bed capacity by another 224 beds.

Prince Edward Island

O'LEARY. Approval for the construction of a hospital at O'Leary has been given by the Provincial Government. It will be known as the Community Hospital. The estimated cost is $90,000 and space will be provided for 27 beds and six bassinettes, an x-ray department, laboratory, operating room, pediatric ward, delivery room, nursery, administration office, and modern kitchen facilities, with dining room for the staff. Work is expected to commence in the near future. The hospital will serve approximately 5,000 people.

Newfoundland

BUCHANS. Work now is under way on a new 20-bed hospital, replacing the present 28-year-old building. Of modern design throughout, the structure will take a year to complete at an estimated cost of $500,000. Adjoining the cruciform-shaped building will be the staff residence connected to it by a covered walk-way. Excavation is now completed and concrete footings have been poured.

International College of Surgeons to hold Annual Congress

The 21st annual congress of the United States and Canadian sections, International College of Surgeons, will be held in the Palmer House, Chicago, September 9th to 13th. The meeting will be attended by surgical celebrities from many foreign countries as well as from all parts of the United States and Canada.

The Canadian section will hold a business meeting Monday afternoon and its dinner will be given that evening. A daily program will be presented by the Women's Auxiliary. There will be daily tours through the International Surgeons Hall of Fame.

Further information may be had by writing to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

Administrator Available

Twelve years in the hospital field in England. Was assistant administrator of Loughborough General Hospital in Leicestershire for over three years. Would accept post of assistant administrator. Box No. 837S, The Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

Medical Records Librarian Wanted

To take charge of department in new hospital of 245 beds. Excellent salaries and personnel policies. Apply—The Administrator, Sudbury Memorial Hospital, Regent Street South, Sudbury, Ont.

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Position Wanted

Mature registered nurse desires a position as a receptionist or an assistant in the medical record department of a hospital. Services available September 1st. Please reply to Box 826 I, The Canadian Hospital, 57 Bloor St. W., Toronto.

Registered Medical Record Librarian Wanted

Required immediately, Registered Medical Record Librarian to assume full responsibility of Medical Record Department in 800 bed hospital. Salary commensurate with qualifications and experience. Address inquiries to: Personnel Office, Regina General Hospital, Regina, Saskatchewan.

Assistant Dietitian

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Presently employed, seeks similar post, four Western provinces prefered. Object: good future prospects. Please reply Box 814S, The Canadian Hospital, 57 Bloor St. W., Toronto.

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R.R.L. required for immediate appointment to head organized Medical Records Department. Attractive salary offered commensurate with experience.

Enquiries stating training, experience and references, as well as recent photograph, invited by A. K. McTaggart, Administrator, Brandon General Hospital.

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Queensway General Hospital Toronto 14, Ont.

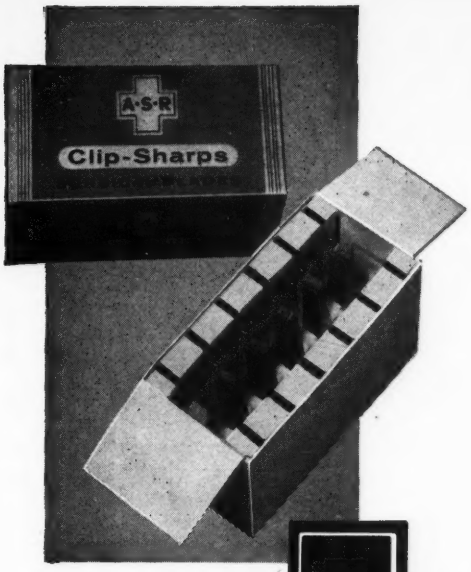
Is accepting applications for employment in all nursing Departments

Supervisors — Head Nurses
General Staff — Nursing Assistants — Orderlies — Ward Secretaries

Newest hospital in Toronto, situated on The Queen Elizabeth Way, 12 miles from downtown Toronto. Attractive residence facilities available in the new apartment type residence. Hospital scheduled to open August 1, 1956. Excellent salaries and personnel policies. Apply Director of Nursing, Queensway General Hospital, Toronto 14, Ont.

Director of Nursing Education Required

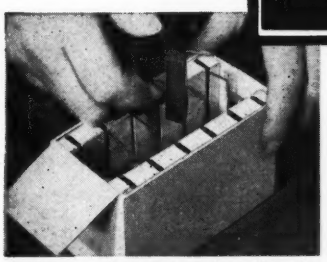
Prince County Hospital, Summerside, P.E.I. requests applications for position of Director of Nursing Education and Nursing Service. A fully accredited voluntary general hospital, 116 beds, and School of Nursing, 36 students. To act as assistant to administrator, teach science subjects and plan curriculum. Degree desirable but not a requirement. Several years supervising and/or instructor experience is required in lieu of degree. Salary to be mutually agreed upon. Private living quarters in new residence. Assistant Instructress and diploma supervisors to assist in clinical teaching. Apply to: Administrator, Prince County Hospital, Summerside, P.E.I.



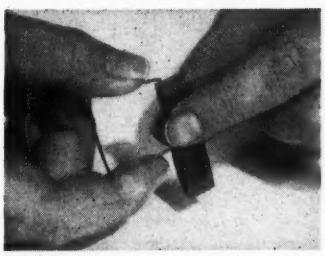
now! quick, easy blade sterilization with

A·S·R Clip-Sharps

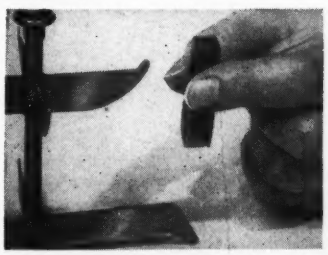
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

Clip-Sharps® are convenient wire clips containing 24 unwrapped A.S.R. Command Edge Surgical blades. There are six clips per box, protected by rust inhibiting paper.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

If you do not wish to sterilize the entire clip of 24 blades, remove only the required number from the clip and place them on the rack arm.

All A.S.R. Surgical Blades are Sharpometer tested. The A.S.R. Sharpometer, *only* device of its kind, measures the critical edge-fineness of every lot of A.S.R. Surgical Blades. These tests enable A.S.R. to guarantee . . . precise, uniform sharpness and dependability for every single blade!

"**NOW!** For extra convenience, blades are alternated on clips".

A·S·R **HOSPITAL DIVISION**
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If your regular dealer cannot supply, send us his name or write directly to our subsidiary:
Personna Blade Co. of Canada, Limited, 2055 Desjardins Ave., Montreal, Quebec

News Released by Hospital Supply Houses

By C.A.E.

Unique Additive Vial Available

A unique device for adding supplemental medication to bulk parenteral solutions has been developed by Travenol Laboratories, Inc., pharmaceutical products division of Baxter Laboratories, Inc.

Called Incert, the new additive vial permits direct, aseptic transfer of medication without the use of needle and syringe, thus providing improved sterility control with added advantages of speed and economy. Use of Incert vial also eliminates the hazard of breaking glass ampules.

Five liquid or dried medications currently are available in Incert additive vials: B vitamins with C (lyophilized), succinylcholine chloride (500 and 1000 mg. concentrations), potassium chloride (20 to 40 mEq. concentrations), potassium phosphate (30 mEq. K) and calcium levulinate (6.5 mEq. Ca).

Automatic Bedpan Washer Steamer

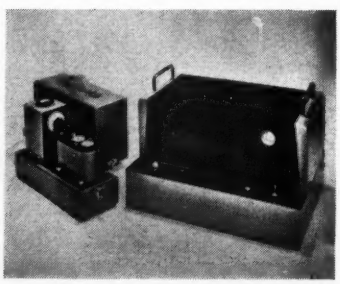
The new Wilmot Castle Automatic Bedpan Washer-Steamer is the first such unit to be equipped with emergency manual control in case of hospital power failure. According to the company, the new "push-button" control unit saves time by eliminating all need for the operator to wait at the unit, time sequences, or make return trips to open and close valves. The cycle is electromatically timed and cannot be interrupted, giving assurance that each bedpan or urinal is thoroughly washed and steam decontaminated for the full period necessary. Possibility of human error is ruled out, according to Castle.

Electromatic valve operation conserves steam and water, lowering operating expense, and the emergency manual control feature insures continuous service where other units are inoperative.

Colson Introduces Cuvette Densitometer

An electronic device, which facilitates diagnosis of blue baby conditions and other cardiac diseases, has been introduced by Colson (Canada) Ltd., Toronto 15, Ont.

The device, a cuvette densitometer, is an optical instrument which gives the physician continuous information on variations in the oxygen saturation of blood taken from specific regions of the heart through a catheter. The catheter, a thin plastic tube, previously has been passed into the heart through an arm vein.



By ascertaining the position of the catheter in the heart by X-ray, the physician can determine the positions in the heart at which the patient's blood departs from the normal oxygen saturation.

The location of this specific region of the heart is an important key to the diagnoses of malformations of the heart.

Determination of oxygen saturation is now mainly done on blood samples removed by catheter and later taken to the laboratory for analysis. With the cuvette densitometer the blood flows directly from the catheter through the instrument, giving the physician a running account of oxygen saturation as he moves the end of the catheter to various areas in the heart.

New Electronic Oxygen Analyzer

The O.E.M. Corporation, East Norwalk, Connecticut, manufacturers of oxygen therapy equipment, have announced the development of a new electronic oxygen analyzer that features portability and simplified operation.

This light-weight, battery operated analyzer enables inexperienced personnel to get accurate readings within 30 seconds and, should the need arise, easily recalibrate it within a few minutes. The highly precise mechanism is housed in a strong plastic case which makes it well suited to rough, daily usage in hospital patient rooms and wards.

The unit is electronically activated with a readily available 4½ volt portable radio A battery that does not have to be replaced until after approximately 5,000 tests.

This new analyzer permits frequent routine checking in hood and tent therapy where there is always the possibility of oxygen escaping through improper tucking of the canopy, too frequent opening of zippers or inadequate liter flow.

(Continued on page 104)

Across the Desk

(Continued from page 102)

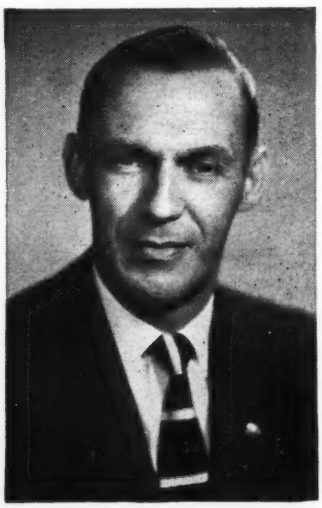
Ingram & Bell Distributes Shroudpac

Ingram and Bell Limited have been appointed exclusive Canadian distributors for Shroudpac, a new product manufactured by Patton Hall, Inc., Chicago. Shroudpac provides a uniform, economical procedure for handling the deceased. It is a self-contained kit, complete with leak-proof plastic shroud sheet, cellu-cotton pads, chin strap, ties, and three identification tags. The polyethylene bag which houses each Shroudpac kit is designed to hold the personal belongings of the deceased. Shroudpac is available both in an adult and a child size.

With this kit, even untrained hospital personnel may be detailed to the preparation of the deceased.

G. H. Wood & Company, Ltd. Appointment

Geoffrey H. Wood, President and General Manager, G. H. Wood and Company Limited, announces the appointment of Tom H. Proctor as General Sales Promotion Manager of the Company's three Industrial Divisions, General, Cleaning Maintenance and Paper. Mr. Proctor is president of the newly formed Sales Promotion Executives Association.



Tom H. Proctor

Interesting Book on Nickel

The International Nickel Co. of Canada Limited have published an interesting book which contains reprints of advertisements published by the Company since 1932. The advertisements were directed to readers interested in many trades and professions. Hospital readers will be interested in the following episode which was reported about six years ago.

"An American research scientist arrived in Bolivia where a typhus epidemic was raging. He had 200 grams —the total world's supply — of a new and untested drug called Chloromycetin which had been developed by Parke Davis and Co.

There was just enough to treat 22 patients. All were seriously ill — some with signs of certain death.

A death certificate had already been made out for one typhus victim. Forty minutes after receiving Chloromycetin, he asked for a drink of water.

Within a few hours after the drug was administered, many of the 22 showed marked improvement. All recovered! Chloromycetin went into full production.

In the processing of Chloromycetin and other pharmaceuticals, corrosive conditions develop. Nickel or nickel alloys play an important part in protecting the product from contamination by metallic compounds."

The International Nickel Co. merit congratulations on their tremendous contribution to the development of Canada, and for their part in promoting the use of nickel which is so important in the daily life of every Canadian.

G. V. Tristram Rejoins Liquid Air

After an absence of two years in the United States, where he was the technical representative for the McKesson Co., based in Chicago and covering Eastern Canada, Gordon Victor Tristram has rejoined Canadian Liquid Air Company Limited, Medical Gas Division; according to an announcement by the company. Mr. Tristram has been appointed medical and technical representative, and will work out of the company's Toronto office.

G. V. Tristram

Mr. Tristram has long been associated with the technical service to hospitals, particularly in the field of anaesthetic equipment. His wide experience is at the service of Liquid Air Medical Gas customers in his territory.

R. A. Prowse Appointed President

Russel A. Prowse, general manager of Garland-Blodgett Ltd., Toronto was appointed president at the annual stockholder and board of director meetings of Garland-Blodgett Ltd., manufacturers and distributors of gas cooking equipment...

Mr. Prowse, who will continue to serve as general manager also, announced that expansion activities along lines of established policies will be reported shortly.

Russel A. Prowse

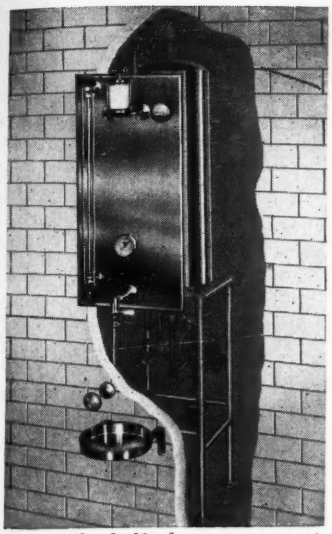
New Doho Topical Anaesthetic

The Doho Chemical Corporation, Varick St., New York, recently announced a new product, Dermoplast Aerosol, a topical anaesthetic for individual therapy in the hospital.

It provides new relief of surface pain and itching without touching affected areas. Dermoplast is indicated for perineal suturing, haemorrhoids, pruritus ani, prurtis vulvae, wounds, burns, abrasions and sunburn.

New Automatic Pressure Water Sterilizer

With the development of Shampaine Electric's new "Aquamat", an automatic pressure water sterilizer, sterile water may now be drawn from a single tank, which automatically maintains sterile water at body temperature, or at any other selected temperature. This eliminates mixing sterile water from conventional, dual-type hot and cold pressure tanks to obtain water of the required temperature. A further advantage is that the single tank method



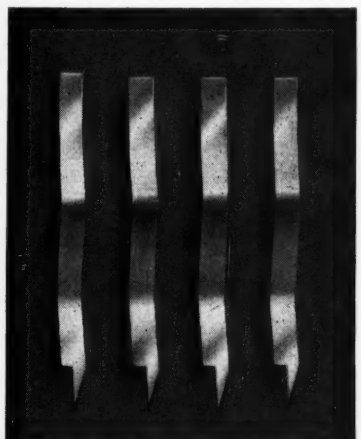
utilizes only half the space required by the conventional two-tank sterilizer.

For complete information, write to Shampaine Electric Company, 50 Webster Avenue, New Rochelle, N.Y.

Husband, answering telephone: "I don't know. Call the weather bureau."

Pretty young wife: "Who was that?"

Husband: "Some sailor, I guess. Wanted to know if the coast was clear."



Index of Advertisers

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